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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

AMERICANA HEALTHCARE CORPORATION; ELKHART AMERICANA, INC., d/b/a AMERICANA HEALTHCARE CENTER OF ELKHART; CAPITOL AMERICANA, INC., d/b/a AMERICANA HEALTHCARE CENTER OF INDIANAPOLIS—MIDTOWN,
Petitioners,

vs.

RICHARD SCHWEIKER, Secretary, Department of Health & Human Services,
Respondent.

TURTLE CREEK CONVALESCENT CENTERS, INC., d/b/a NORTHSIDE HEALTHCARE CENTER,
Petitioner,

vs.

RICHARD SCHWEIKER, Secretary, Department of Health & Human Services,
Respondent.

CARE INNS, INC., d/b/a CLARKSVILLE HEALTHCARE CENTER,
Petitioner,

vs.

ROBERT F. SMITH, Acting Administrator, DONALD L. BLINZINGER, Administrator, Indiana Department of Public Welfare,
Respondents.

(Continued Inside Front Cover)

CARE INNS, INC., d/b/a CLARKSVILLE HEALTHCARE CENTER,
Petitioner,

vs.

RICHARD SCHWEIKER, Secretary Department of Health & Human Services
Respondent.

LAURA HATHAWAY, d/b/a R.N. Nursing Home,
Petitioner,

vs.

RICHARD SCHWEIKER, Secretary Department of Health & Human Services,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTIONS PRESENTED

There are three questions presented to the United States Supreme Court by this case:

1. Did the United States District Courts have mandamus jurisdiction pursuant to 28 U.S.C. §1361 to order the Secretary of the Department of Health and Human Services, to comply with the recently enacted Omnibus Reconciliation Act of 1980, P.L. 96-499, to accord nursing care facilities evidentiary hearings prior to termination from the Medicare and Medicaid Programs.

2. Under the facts herein, did the Petitioners raise colorable constitutional claims sufficient to confer subject matter jurisdiction on District Courts pursuant to 42 U.S.C. §405(g).

3. Did District Courts have subject matter jurisdiction pursuant to 28 U.S.C. §1331(a), and did the District Court in No. 81-2873, Care Inns, properly exercise pendent jurisdiction over state defendants in litigation involving continued participation in the Medicaid Program.

PARTIES TO THE PROCEEDING

The parties to the proceedings in the courts below are listed in the caption to this Petition.[1] Additionally, Judy Carrothers was a plaintiff in the Laura Hathaway case, but is not a petitioner before this court.

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[1]Pursuant to Supreme Court Rule 28.1, Petitioners note that the parent corporation of Turtle Creek Convalescent Centers, Inc. and Care Inns, Inc. is ARA Healthcare Management, Inc. of Houston, Texas, which is a wholly owned subsidiary of ARA Services, Inc. Americana Healthcare Corporation is a wholly owned subsidiary of Manor Care, Inc.

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THE OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit appears in Appendix A herein, *infra*, at p. A-1, and is reported at 668 F.2d 1062 (7th Cir. 1982). The Providers Petition for Rehearing and Suggestion for Rehearing En Banc was denied without written opinion. The Order denying Petition for Rehearing and/or Suggestion for Rehearing En Banc is included herein as Appendix C, at p. A-83.

The District Courts' Findings of Fact, Conclusions of Law and Entries of Judgment in the Care Inns, Inc. and Turtle Creek Convalescent Center, Inc. cases are not reported. They are reprinted in Appendix B, at pp A-74 and A-35, respectively. The Preliminary Injunction in the Americana Healthcare Corporation case is not published. It is reprinted in Appendix B, *infra*, at p. 32. The Restraining Order and Order for Hearing, Agreed Entry of January 14, 1981 and the Entry of January 27, 1981 in the Laura Hathaway case were not published. They are reprinted in Appendix B, *infra*, at p. A-76.

JURISDICTION

The Judgment of the Court of Appeals was entered on August 18, 1982. Petitioners' Petition for Rehearing and/or Suggestion for Rehearing En Banc was denied on October 8, 1982. The jurisdiction of the United States Supreme Court is invoked pursuant to the provisions of 28 U.S.C. §1254(1)(1976).

CONSTITUTIONAL PROVISIONS INVOLVED

The constitutional provision involved is the Constitution of the United States—Amendment V:

> "No person shall be...deprived of life, liberty, or property, without due process of law...".

STATUTORY PROVISIONS INVOLVED

The statutory provisions of primary importance to this Petition are 42 U.S.C. §1395cc(f) (1976 & Supp. 1982), 42 U.S.C. §1396a(i) (1976 & Supp. 1982), 42 U.S.C. §1396i(c) (1976 & Supp. 1982), 42 U.S.C. §405(g) (1976 & Supp. 1981) and 42 U.S.C. §405(h) (1976 & Supp. 1981), all of which are reprinted in Appendix D, at pages A-84, A-86, A-88, and A-89, respectively.

STATEMENT OF THE CASE

A. Nature of the Case.

In each of these actions, consolidated for purposes of appeal, the respective Petitioners filed actions in District Courts seeking injunctive relief, and stay of administrative orders. Named as defendants were the Secretary of the Department of Health and Human Services (hereinafter the Secretary and/or HHS) and the Indiana Department of Public Welfare (hereinafter DPW). Each Petitioner owned or operated nursing care facilities and each requested the District Courts to enjoin the discontinuation of participation of Petitioners' facilities in the Medicare and/or Medicaid Programs until a hearing was provided. This relief was requested since the respondents' actions to terminate Medicare and/or Medicaid participation, if not halted, would have resulted in the involuntary relocation of Petitioners' patients to other nursing homes, thereby causing incalculable, and perhaps fatal, injury to both the patients and financial ruination to the Petitioners.

B. The Statutory and Regulatory Framework.

"Medicare" is the common name for Federal Health Insurance for the Aged and Disabled and is set forth in Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq. (1976 & Supp. 1982). Part A of this program provides hospital and skilled nursing facility benefits to older Americans. It is totally federally funded and is administered by the Secretary of Health and Human

Services, although the actual inspecting of Medicare-approved facilities is routinely conducted by designated state agencies by contract. In Indiana it is the Indiana State Board of Health which performs the inspections for HHS.

Medicaid, established in Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.* (1976 & Supp. 1982) is principally intended to provide medical insurance benefits to poor individuals. The costs of Medicaid are shared by federal and state governments. (In Indiana, the federal government pays roughly 53% and the State pays 47%). The administration of this program is conducted by a designated state agency, 42 C.F.R. §431.10 (1980), which in Indiana is the Department of Public Welfare (DPW). The operation of the Indiana Medicaid Program is statutorily governed by IC 12-1-7-14.9 *et seq.* (Ind. Legislative Council 1980 Cumm. Supp.).

Medicare and Medicaid share the feature that payment for care rendered to beneficiaries in the program is made directly to the health care provider. 42 U.S.C. §1395d (1976) and §1395f (1976). In order to be eligible to receive reimbursement for care provided to Medicare or Medicaid beneficiaries, a facility must be "certified" under the appropriate program. To be eligible for certification a facility must meet certain "conditions of participation", 42 C.F.R. §489.10 (1980); 42 C.F.R. §442.100 (1982), which describe minimum requirements with respect to nursing, management, physical design, dietary administration and therapeutic services. 42 C.F.R. §442.300 *et seq.* (1978); 42 C.F.R. §405.1101 *et seq.* (1975). If a facility wishes to be certified under either Medicare or Medicaid, an inspection is made by a designated state survey agency (in Indiana, a division of the Indiana State Board of Health (ISBH)). Under Medicare the results of this survey, are reported to HHS's Health Care Financing Administration (HCFA). 42 C.F.R. §405.1902(a) (1980).

Under Medicaid the state survey agency is responsible for making the decision as to whether a facility is eligible to be certified, 42 C.F.R. §431.610(e)(1) (1980), and reports this decision to the State Medicaid agency. The final step for participation under these programs is the execution of a provider agreement. Under Medicare this agreement is between the facility and HHS, 42 C.F.R. §489.11 (1980) and under Medicaid it is between the facility and the state Medicaid agency. 42 C.F.R. §442.12 (1980).

These programs include two levels of nursing care, designated as skilled and intermediate care, which are distinguished chiefly by the intensity of care provided. Skilled care is the more intensive, as measured by the average number of nursing hours per patient per day. In Indiana Medicare reimburses only skilled care, while Medicaid pays for both skilled and intermediate care. A facility may be certified as a skilled nursing facility (SNF), or an intermediate care facility (ICF) or, if so qualifying, may choose to have one portion SNF-certified and another portion ICF-certified. Since the certification requirements for an SNF under Medicare are identical to those for a SNF under Medicaid, certification under Medicare automatically establishes eligibility under Medicaid.

Provider agreements are technically of limited duration. Generally, the agreements with facilities that are in full compliance with conditions of participation are limited to twelve months under both programs, 42 C.F.R. §489.15(b) (1980); 42 C.F.R. §442.15(a) (1982). Certain conditions may give rise to temporary extensions of the agreement period. 42 C.F.R. §489.15(c) and (d) (1980); 42 C.F.R. §442.16 (1982).

In addition to conducting pre-certification inspections, the state survey agency is responsible for periodic inspections of participating facilities to insure continued compliance with conditions of participation.

In the Medicare Program, HCFA of HHS may terminate a provider agreement upon a finding that the facility no longer meets conditions of participation, or on several other bases specified at 42 C.F.R. §489.53 (1980).[2] Each condition of participation is divided into "standards", which are further subdivided into "elements". Compliance surveys are conducted by surveyors from the designated state agency, 42 C.F.R. §405.1903 (1980).

Under Medicaid the federal regulations do not set forth a "laundry list" of reasons for terminating a provider agreement. The bases for cancellation of participation are left to the state Medicaid agency, although it is required that the agency have "... adequate documentation showing good cause..." 42 C.F.R. §442.12(d) (1982).[3] Since it is charged with administering the agreement, typically the decision to terminate a provider agreement under Medicaid will come from the state Medicaid agency. However, the Secretary of HHS retains the power to "look behind" the findings and recommendations of the designated state agencies where the Secretary has reason to question their reliability. In such instances the Secretary may unilaterally terminate the Medicaid agreement. See 42 U.S.C. §1396i(c) (1981). Furthermore, the termination by the Secretary of HHS of a Medicare agreement will necessarily require the state agency to terminate any agreement with the same facility which covers Medicaid-SNF care. 42 C.F.R. §442.20(b) (1980).

In Indiana DPW is statutorily prohibited from using State funds under Medicaid to reimburse a provider where the federal portion of the payment has not, or will not, be

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[2]HHS has not amended this regulation subsequent to the passage of the Omnibus Reconciliation Act of 1980, P.L. 96-499, 42 U.S.C. §1395cc(f) (1981).

[3]See 42 U.S.C. §1396(a)(i) (1981) as to state agency requirements under the Omnibus Reconciliation Act of 1980, P.L. 96-499.

provided by federal authorities. IC 12-1-7-14.9(b) (Ind. Legislative Council 1980 Cum. Supp.). The survey process under Medicaid is essentially identical, both substantially and temporally, with that of Medicare.

Following surveys under Medicare or Medicaid, the surveyors prepare findings as to a facility's compliance with applicable regulations. If deficiencies in elements are found, the facility may respond to the survey agency with a "plan of correction" describing the efforts to be taken to cure deficiencies that are admitted. Even with deficiencies present, a plan of correction acceptable to the secretary or the state agency will allow continued Medicare or Medicaid participation, respectively, so long as the deficiencies do not immediately jeopardize safety of patients. 42 C.F.R. §§405.1907 (1980), 442.105 (1980). If, however, the secretary finds that a facility no longer substantially meets conditions of participation, a facility cannot continue to be certified. 1395cc(b) (1976 & Supp. 1982).

In the event that conditions of participation are found unmet, a Medicare facility is notified by HHS that an "initial determination" has been made to this effect.[4] If the facility objects, it may then request the Secretary to "reconsider" this "initial determination", 42 C.F.R. §405.1510—1521 (1982). The facility may then appeal the initial determination and request an administrative hearing. 42 C.F.R. §489.53(c) (1980), 42 C.F.R. §§405.1551, *et seq.*, (1982).[5] If the result of the administrative hearing is adverse, the facility may then appeal to an "Appeals Council". 42 C.F.R. §405.1561, *et seq.* (1982). The finding of

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[4]In the Medicaid context in Indiana, a similar notice is sent to the facility by DPW.

[5]Under Medicaid the hearing must be held before the effective date of termination or within 120 days thereafter. 42 C.F.R. §431.53(b) (1979). Again, however, the Secretary has not amended these regulations to conform with 42 U.S.C. §1395cc(f) (1976 & Supp. 1982).

the Appeals council becomes the Secretary's "final determination" and the provider may then seek judicial review. 42 C.F.R. §1567 (1982). There is no provision allowing the Secretary to cease making payment before the "final determination" in either the Statutes or the Regulations.

C. **Statement of the Facts.**

No. 81-C-929, *Care Inns, Inc.* operates a Medicare and Medicaid certified nursing facility in Clarksville, Indiana. In a letter dated July 22, 1981, the Secretary notified Care Inns that, based on a state survey conducted in May, 1981, its Medicare agreement with the HHS would not be renewed effective September 1, 1981. The Secretary stated that the survey showed the facility had deficiencies which "immediately jeopardize the health and safety of the patients". Care Inns disputed the survey and requested a resurvey and a pre-termination hearing, the latter of which was denied by the Secretary. A resurvey was conducted on August 10th and 11th, 1981, and the facility was found to be in compliance with all Medicare conditions of participation. On August 25, 1981, representatives of the facility and the Secretary met and the HHS was requested to reconsider its original decision based upon the facility being in compliance. Representatives of the Secretary, however, announced that they maintained their original decision and, furthermore, reconsideration of their decision would not be completed until after the effective date of non-renewal. On August 31, 1981, Care Inns filed an action in the Federal District Court seeking injunctive relief to prevent the Department and DPW from terminating the facility from Medicare and Medicaid prior to a hearing, noting that the survey agency had found the facility in compliance. The District Court conducted a bench trial on the merits consolidated with a preliminary injunction hearing and found that no emergency existed at the facility

which justified the Department's denial of renewal. The injunctive relief requested by Care Inns was granted.

No. 80-C-1267, *R.N. Nursing Home* is located in Teagarden, Indiana, and is certified as a Medicaid provider only. In a letter dated December 4, 1979, the R.N. Nursing Home (R.N.) was notified by DPW that it was to be decertified from Medicaid participation as a result of state survey. R.N. requested that DPW conduct a hearing prior to decertification. Upon agreement of the parties' attorneys, this hearing was postponed pending the outcome of a State licensure proceeding involving allegations of the same deficiencies. The licensure proceedings were completed on August 18, 1980 and the home was accorded full licensure. DPW took no action subsequent to the facility being accorded full licensure. On September 23, 1980 HHS notified DPW that federal matching funds for state Medicaid payments for R.N. would be deferred because R.N. was not in compliance with Medicaid regulations. On December 19, 1980, DPW notified R.N. that it was required to defer any payment to the facility because state law prohibited the disbursement of state funds without federal matching funds. R.N. then commenced its action seeking to enjoin HHS and DPW from discontinuing R.N.'s reimbursement for care given to Medicaid patients. Following a conference before the District Court, at which all parties were represented, an agreed Temporary Restraining Order was granted on December 31, 1980, and this Order was subsequently continued by agreement on January 14, 1981, and by court order on January 27, 1981.

No. 81-C-58, *Americana Healthcare Corporation* owns and operates two nursing facilities in Indiana which were the subject of this litigation. Both facilities were certified to participate in the Medicare and Medicaid Programs. On October 22, 1980, HHS sent a letter to the Americana

facility at Elkhart (Americana-Elkhart) stating a survey had been conducted at this facility by the Indiana State Board of Health in August of 1980 and that deficiencies had been identified which "seriously limit your capabilities to render adequate care and insure the health and safety of your patients." The letter stated that HHS would not renew its Medicare agreement with Americana-Elkhart which would expire on December 1, 1980. This facility disputed the survey and timely requested a reconsideration of the Secretary's decision and a pre-termination hearing. HHS denied the request for such a hearing. A resurvey of the facility was conducted by the same state agency and HHS subsequently reaffirmed its decision to deny renewal of the facility's agreement, but extended the effective date of non-renewal until January 31, 1981. Subsequently Americana-Elkhart was notified by DPW that as a result of the Secretary's decision, the facility's Medicaid agreement would also not be renewed.

The other Americana facility involved in this action is located in Indianapolis (Americana-Midtown). By letter dated October 24, 1980, HHS notified Americana-Midtown that as a result of a State survey conducted in August, 1980, its Medicare agreement with the HHS would not be renewed effective December 1, 1980, using language operatively identical to that received by Americana-Elkhart. Americana-Midtown disputed the survey and timely requested both reconsideration and a pre-termination hearing. The hearing was refused but another survey was conducted by the State agency and the facility was subsequently informed by HHS that its original decision would be reaffirmed but that the effective date of non-renewal for this facility would also be backed up to January 31, 1981.

On January 27, 1981, these facilities commenced an action in the Federal District Court seeking injunctive relief against the Secretary and DPW seeking to prohibit

these agencies from terminating the facilities' participation in the Medicare and Medicaid Programs without pre-termination hearings based upon both the Secretary's existing rules and the Omnibus Reconciliation Act of 1980, 42 U.S.C. §1395cc(f) (Supp. 1982). Following an evidentiary hearing before the District Court, a preliminary injunction was issued against the Secretary and DPW.

No. 81-C-172, *Turtle Creek Convalescent Centers, Inc.* operates a Medicare and Medicaid certified nursing facility in Indianapolis (Northside). In a letter dated January 22, 1981 HHS informed Northside that a state survey conducted in November of 1980 had indicated deficiencies at the facility which "seriously limit your capability to render adequate care and insure the health and safety of your patients." HHS stated that it would not renew the facility's Medicare agreement scheduled to end March 1, 1981. The facility disputed the survey and timely requested reconsideration of the Secretary's decision and a pre-termination hearing. The hearing request was denied. The State agency began a resurvey of the facility on February 9, 1981, but this was discontinued when the facility was informed that the surveyors were bound to review and base their recommendations on entries in patient records which predated the survey of November, 1980. Documentary deficiencies in the pre-November 1980 patient records had been a principal focus of criticism of the facility following the November survey and, by law, could not be corrected. HHS then reaffirmed its original decision and Northside was subsequently notified by DPW that, as a result of the HHS action, DPW, too, was bound to discontinue Northside's Medicaid participation. Prior to the effective date of the sanctions threatened by DPW and the HHS, Northside commenced an action in the Federal District Court seeking injunctive relief prohibiting the termination of the facility's participation in Medicare and

Medicaid without a pre-termination hearing again based upon regulations as well as the Omnibus Reconciliation Act. At the conclusion of a bench trial, the District Court entered a permanent injunction preventing the Secretary and DPW from decertifying Northside prior to according the facility a pre-termination hearing as the state clearly requires.

In each of the foregoing actions, with the exception of Hathaway, the defendants challenged the district courts' subject matter jurisdiction, and this was the sole question for appeal raised by the Secretary. The state defendant DPW appealed in Care Inns, Inc. only and challenged the District Court's exercise of pendent jurisdiction.

D. Basis for Federal Jurisdiction in District Court.

In each of these actions, the Petitioners alleged before the Federal District Courts jurisdiction pursuant to 28 U.S.C. §1331(1976 & Supp. 1982), 28 U.S.C. §1361 (1976 & Supp. 1982), 5 U.S.C. §701 (1976), and 42 U.S.C. Chapters XVIII (which incorporates by reference 42 U.S.C. §405 *et seq.*) and XIX.

ARGUMENT

1. District Courts Clearly Had Mandamus Jurisdiction Pursuant to 28 U.S.C. §1361 to Order Compliance by the Secretary of the Department of Health & Human Services with Certain Directives Contained in the Newly Enacted 42 U.S.C. §1395cc(f).

In the District Courts the Petitioners invoked subject matter jurisdiction pursuant to 28 U.S.C. §1361 (1976 & Supp. 1982), arguing that the Secretary had failed to comply with the clear directives of §916 of the Omnibus Reconciliation Act of 1980, P.L. 96-499, now codified at 42 U.S.C. §1395cc(f)(1976 & Supp. 1982) (hereinafter referred to as ORA). The applicable provisions of the Act are as follows:

"SEC. 916 (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under Title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

"(2) *The Secretary shall not make such a decision* with respect to a facility *until such facility has had a reasonable opportunity,* following the initial determination that it no longer substantially meets the provisions of section 1861(j), *to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.*" [Emphasis Added]

Petitioners argued that the ORA clearly required the Secretary to offer a meaningful hearing prior to making any final decision to impose any sanctions on a provider against whom deficiencies are alleged. Alternatively, the

Petitioners argued that, at a minimum, they were entitled to a hearing in circumstances where the health and safety of patients were not immediately jeopardized. Noting that every District Court presented with evidence had concluded that no emergency or immediate jeopardy whatsoever existed at their facilities, the Petitioners argued that under *Cervoni v. Secretary of H.E.W.*, 581 F.2d 1010 (1st Cir. 1978) they had a clear right to relief and that mandamus was the proper remedy to force the Secretary to comply with the clear dictates of the ORA.

The Seventh Circuit concluded in its opinion that there was no right to a hearing where immediate jeopardy existed and, citing this Court's recent decision in *Youngberg v. Romeo*, ___ U.S. ___, 73 L.Ed. 2d 28, 50 U.S.L.W. 9681 (1982), found that the question of the existence of immediate jeopardy was not a proper consideration for the District Courts but rather should be deferred to the expertise of the *licensing agency*. Opinion p. 34. Presuming that the Secretary had found the presence of immediate jeopardy in each of these cases, the Seventh Circuit concluded that the Petitioners had no clear right to a pre-termination hearing and that mandamus jurisdiction was inappropriate.

The blatant error in the Seventh Circuit's reasoning is that it abhors both the facts in these actions and the applicable law. Factually, that Court disregarded the findings of three District Court Judges who had concluded that no evidence was presented which substantiated the mere allegations of the Secretary. The Seventh Circuit also was apparently oblivious to the fact that the *licensing agency*, toward which it contended deference should be shown, was not the Secretary but was in fact the Indiana State Board of Health—officials who admitted that they had taken no action commensurate with a finding of "immediate jeopardy". The official of the Secretary's office in charge of facilities in Indiana himself testified he had elected to let the Petitioners' provider agreements "expire",

thereby allowing the Petitioners' patients to remain at the facilities for months. Had this truly been a situation of immediate jeopardy, the actions of the Secretary would have been inconsistent with the ORA, which clearly directs the Secretary to proceed to terminate a facility's participation and cease payments for future patients. Finally, with the exception of Care Inns, in none of these actions did the Secretary's notice to the Petitioners contain allegations of "immediate jeopardy".

Legally, the Seventh Circuit relied on incomplete principles of administrative law to reach its conclusion that the District Courts had somehow abused their discretion. While relying on the deference principle articulated in *Youngberg, supra*, the Court ignored the corrolary set forth in *Bell v. Woolfish*, 441 U.S. 520 at 528 (1979), in which it was stated that the deference principle is not applicable where there is "...substantial evidence in the record to indicate that the officials had exaggerated their response...". While recognizing the utilitarian value of deferring factual determinations to responsible administrative agencies, this Court has long recognized that such deference should be no bar to judicial intervention where agency action is patently arbitrary, capricious or without foundation. *Joint Anti-Facist Refugee Committee v. McGraf*, 341 U.S. 123 (1950).[6]

Thus, by second guessing the triers of fact the Seventh Circuit framed an unnecessary issue—whether hearings are required in situations of immediate jeopardy—and answered this issue in the negative. Nevertheless, the Petitioners submit that the ORA does in fact call for a

[6]It must be presumed that the District Courts were acutely sensitive to the allegations made by the defendants and that the injunctive relief, if granted, would allow the allegedly threatened patients to remain in Petitioners' facilities. Further, any patient has the right to leave a facility if the care rendered is believed inadequate. 42 C.F.R. §405.1121(k)(1982).

hearing regardless of whether immediate jeopardy is alleged by the Secretary. This interpretation is supported by the language of the Act on its face. The "decision" referred to in sub-part 2 can logically only refer to the Secretary's "determination" in sub-part 1. It is a standard rule of statutory construction that where several words in a statute ("where the Secretary determines") are followed by a general clause ("the Secretary shall not make a decision") which is as applicable as much to the first and other words as to the last, the natural construction of the language demands that the clause be read as applicable to all. *Porto Rico Railway, Light & Power Company v. Mor*, 253 U.S. 345 (1920); see also *Fundamentals of Legal Drafting, Dickerson*, (1965), p. 86.

Petitioners interpretation is also supported by the language of House Conference Report No. 96-1479, pp. 140, 141, reported in (1980) U.S. Code Congressional & Administrative News, 96th Congress, 2nd Session, 9963, 9991-2 wherein the conference committee, describing its intent with respect to the essentially identical duties imposed upon state agencies by §916(b)(2), codified at 42 U.S.C. §1396i(c) (Supp. 1982), stated:

> "Under the conference agreement it is intended that federal financial participation should be continued with respect to Medicaid patients of a facility decertified by the Secretary during such reasonable time as is required to effect the transfer of Medicaid patients from the facility. Further, the conferees note that it is not the intention of this provision to alter access to a full evidentiary hearing *before* decertification of a facility occurs, as provided under current law." (Emphasis added)

The Seventh Circuit's interpretation of the ORA, so clearly contrary to both the facial language and the legislative history, was apparently intended to avoid a result wherein the Secretary would be prevented from

removing patients from an unsafe environment by providers who would exploit appeal procedures to avoid termination from Medicare or Medicaid and, in so doing, would unnecessarily prolong the presence of patients in unsafe surroundings. While the Seventh Circuit's concern is understandable, it misapprehends the position of the Secretary, whose function is merely that of a fiscal agent. The Secretary's responsibility is strictly to ensure that federal monies are not expended on sub-standard facilities. Monitoring the compliance of facilities with Medicare or Medicaid conditions of participation is the function of state inspectors, who perform this task under contract with the Secretary. Federal inspectors rarely set foot inside health facilities and none did so in the present actions. Furthermore, the state *licensing* agency has the responsibility of removing patients from unsafe facilities and it is uncontroverted that no such action was taken against any of the Petitioners herein. Even when substandard conditions are found, the Secretary does not have any authority to remove patients other than those under one of these programs. Privately funded patients could remain. This fact was ignored by the Seventh Circuit but such fact establishes the true parameters of the Secretary's authority and duty. Therefore, the Seventh Circuit's strained statutory construction does not further any persuasive public policy. The ORA established a clear duty on the part of the Secretary, a clear right for the Petitioners, and mandamus jurisdiction pursuant to 28 U.S.C. §1361 (1976) was properly invoked by the District Courts. 42 U.S.C. §405(h) (1976 & Supp. 1981) does not preclude §1361 jurisdiction. As Judge Friendly held in *Ellis v. Blum*, 643 F.2d 68 at 78 (2nd Cir. 1981);

> "...we are satisfied that jurisdiction is provided by 28 U.S.C. §1361 .... An impressive array of cases in this and other circuits has established that §1361 jurisdiction will lie to review procedures employed in administering social security benefits... [Citations

> omitted] ... Even more significantly, this court has twice held since *Salfi* that §405(h) does not preclude mandamus jurisdiction to review the Secretary's procedures in disability cases ...".[7]

Clearly the opinion of the Seventh Circuit is erroneous in this regard.

2. The District Courts Properly Exercised Subject Matter Jurisdiction in These Actions Pursuant to 42 U.S.C. §405(g).

In addition to the statutory challenge discussed under Issue 1, Petitioners in each of these actions argued that the denial of a pre-termination hearing violated due process rights guaranteed under the Fifth Amendment to the Constitution of the United States. It was argued that this challenge presented a colorable constitutional claim, which under this Court's teachings in *Mathews v. Eldridge*, 424 U.S. 319 (1976), constituted an exception to the judicial preclusion aspects of 42 U.S.C. §405(h) (1976 & Supp. 1981), thus conferring subject matter jurisdiction on the district courts pursuant to 42 U.S.C. §405(g) (1976 & Supp. 1981).

The Seventh Circuit held that its own decision in *Northlake Community Hospital v. United States of America*, 654 F.2d 1234 (7th Cir. 1981) was controlling and that the factual position of the Petitioners was not significantly different from the plaintiff in *Northlake*.[8] In

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[7]Judge Friendly's opinion is in accord with this Court's holdings in *Kendall v. United States*, 37 U.S. 524 (1838) and *In Re Heath*, 144 U.S. 92 (1892), wherein the Court held that a new statute which refers to another statute adopts the referred statute as it existed at the time of the new statute's adoption. Section 205 of the Social Security Act (now codified as 42 U.S.C. §405) precludes action under Section 24 of the Judicial Code of the United States. That Code did not encompass mandamus jurisdiction. 42 U.S.C. §405(h), although nominally excluding §1361 jurisdiction, is merely a compilation and has not been passed as positive law.

[8]*Northlake* was decided before the ORA became effective and ORA was not in issue. Furthermore, *Northlake* concerned a hospital not a nursing home, and the ORA applies only to nursing homes—totally distinguishing the applicability of that case.

the *Northlake* case it was held that the due process claim made by the terminated provider was not a colorable constitutional claim. In *Northlake* the Seventh Circuit explored, for *Eldridge* purposes, the private interest affected and the public interest at stake and found these weighing against the plaintiff. In its Opinion in the present actions, the Court's attention was primarily addressed to the *Eldridge* due process analytical factor of risk of error in the procedures preceding deprivation. Specifically, the Court noted that each of the Petitioners were afforded advance notice of the decision to decertify their facilities, that each was informed of the deficiencies upon which the decertification was based, that each was afforded an opportunity for a resurvey to demonstrate corrections, that each was permitted to submit documentation explaining or refuting the deficiencies, and that in the case of Care Inns, Inc. the facility was permitted to meet with employees of the Secretary and submit evidence of compliance prior to the effective date of termination.[9]

There has been no dispositive statement by this Court on a provider's constitutional right to a hearing prior to termination from federal financial participation. The question was indirectly mentioned but not resolved in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, Fn. 17 at 784 (1980).

In each of the District Courts, the Petitioners vigorously applied *Eldridge* due process analysis to the facts at hand; the granting of the relief sought by the Petitioners indicates the persuasiveness of these arguments. In brief, it was argued that the private interest to be considered was the termination of Petitioners' provider status under federal financial participation.[10] In both *Northlake* and

[9]It is again noted that such a procedure does not comply with the requirements of the ORA and the Secretary has refused to implement regulations to comply with this Act.

[10]While there is a technical difference between termination during the term of a provider agreement (decertification) and termination of the end of an agreement (non-renewal) for due process purposes the effect is the same in either action. See *Rockhill Care Center, Inc. v. Harris*, 502 F. Supp. 1227, (W.D. Mo. 1980); *Braceo v. Lackner*, 462 F. Supp. 436 (D. Cal. 1978).

Town Court Nursing Center v. Beal, 586 F.2d 266 (3rd Cir. 1978) this interest was dismissed as less weighty than that of the disability claimant in *Eldridge*. However, continued provider participation has been recognized as a constitutionally recognized property interest, *Hathaway v. Mathews*, 546 F.2d 266 at 230, (7th Cir. 1976), *Case v. Weinberger*, 523 F.2d 602 (2nd Cir. 1975). It was demonstrated to the District Courts in the present actions that continued participation was not simply a convenient revenue generating source; it was absolutely necessary to the Petitioner's continued existence as business entities. For similar findings, see *Rockhill Care Center, Inc., supra; Bracco, supra.*[11] Given the public notice which occurs when a provider is terminated, it is unreasonable to expect that new patients would seek admission, thereby compensating for the loss of Medicaid or Medicare beneficiaries. In addition, unlike the claimant in *Eldridge*, a nursing facility which eventually prevails in the Secretary's administrative channels would not receive retroactive reimbursement for funds wrongfully denied because those patients would have been removed. Furthermore, it is noteworthy that there are absolutely no time limits imposed upon the Secretary for conducting hearings or issuing findings during the administrative appeal of the termination action. In fact, in Care Inns the Regional Director of the Secretary stated that the informal reconsideration of Care Inns would not be completed until after termination. Finally, there is no statutory or regulatory authority for the Secretary's practice of terminating payments and removing patients prior to issuing a final decision. This unauthorized practice points out the need for pretermination hearings. The practice of stopping payments based on "initial

[11] In 1979 the care for over fifty per cent of the average nursing home's patients was paid for by federal financial participation. *Gibson, Robert M., "National Health Expenditures 1979" Health Care Financing Review*, Vol. 2, No. 1, Summer 1980, Government Printing Office.

determination" is unsupported by law and is contrary to the obvious intent of Congress that such an action be taken only after a final decision.[12]

Petitioners argued that the second *Eldridge* review factor, the Government's interest in expeditious deprivation of the private interest, clearly weighed in their favor. The Government's interest was articulated in *Northlake* as being protection of patient safety and in *Town Court* as minimizing undue expenses in administering the Medicare Program. As we noted in Issue 1 above, the patient safety question is a "red herring" since the state licensing agency, not employees of the Secretary, has the day to day responsibility for insuring patient safety and removing all patients (not only Medicare and/or Medicaid patients) from threatening environments. The rationale in *Town Court*, finding this factor in favor of the government, is also wanting since HHS failed to introduce any evidence before that court (or any of the District Courts in these actions) supporting the Secretary's contention that it would be any more expensive to hold a pre-termination hearing as opposed to a post-termination hearing. Certainly, whether or not pre-termination hearings would consitute an onerous administrative burden is not a proper subject for judicial notice, which the Third Circuit appears to have taken in *Town Court*. Since the Secretary's own delays in these cases ranged from 105 to over 400 days, certainly pretermination hearings could easily have been held prior to the effective dates of termination.

The final *Eldridge* factor is the risk of error in the deprivation of benefits. In both *Northlake* and *Town Court* the procedures leading to the termination of benefits were found, as in *Eldridge*, to be carefully structured and narrowly focused. This is not the case in nursing facility termination actions.

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[12]See S.Rep.No. 404 (Part I), 89th Cong. 1st Sess. (1965) *reprinted in* U.S. Code Cong. & Admin. News, 89th Cong. 1st Sess. 1943 and H.R. Rep. No. 213, 89th Cong. 1st Sess. (1965).

Rather than *Eldridge's* simple observation and diagnosis by physicians, the decision to terminate a provider's participation under Medicare or Medicaid is predicated upon reviews of a facility by surveyors with widely differing backgrounds and expertise, utilizing forms prepared by the Secretary which are replete with questions calling for non-quantifiable answers. The importance of the questions on these forms vary widely in their practical significance to patient health and no systematic method is employed to weight these questions in accordance with their significance to patient safety. Additionally, the evidence presented below demonstrated that considerable discretion is allowed to the surveyor in placing an alleged deficiency under one or more conditions of participation. See findings in Appendix B at p. A-69. Individuals who collect the data are state employees but the decision to terminate a provider is made by the Secretary's employees who merely review summaries. In short, as noted in *Rockhill, supra*, the procedures leading to the decision to terminate a provider are significantly more affected by subjective decision making than the narrowly focused medical decision in *Eldridge*. In the present actions, the most graphic examples of a provider's inability to reverse termination actions already in motion occurred in Northside and Care Inns. After Northside received notice of a proposed termination action, it immediately requested a resurvey in order to prove compliance with applicable regulations. Midway through the resurvey the facility was notified that the surveyors were obligated to note deficiencies in patient care documentation which predated the facility's correctional efforts and in fact had been a principal factor in the original termination decision. By law, the facility could not modify this documentation. The resurvey was stopped when the facility realized that, regardless of its correction of deficiencies, the results of the second survey would be as damaging as those in the first. In Care Inns the resurvey was completed and the facility was

found to be in compliance with Medicare conditions of participation. Nevertheless the Secretary arbitrarily persisted in his decision to terminate. When facility representatives presented additional information to the Secretary during the course of the administrative review phase known as "reconsideration", they were notified that the Secretary's reconsideration decision would for some unspecified and obviously arbitrary reason not be forthcoming until an unknown date after termination. Furthermore, in its hearing before the District Court, Care Inns first learned that employees of the Secretary had, prior to making the termination decision, prepared an in-house memorandum setting forth the rationale for their decision, which contained highly negative statements about events at the facility over the past ten years. This memorandum contained no reference to the fact that Care Inns had been operating the facility only for the past two years. The memorandum had never been supplied to the facility so that it could be rebutted.

In view of the highly subjective nature of the provider evaluation process, there is a substantial risk of deprivation and a pretermination hearing is called for in accordance with the principles set forth by this Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970). An analysis of these procedures in light of *Eldridge* clearly supports the Petitioners' claim that they have at least raised a colorable constitutional claim sufficient to allow the District Courts to exercise subject matter jurisdiction over the action pursuant to *Eldridge*, and 42 U.S.C. §405(g).

3. The District Courts Properly Exercised Subject Matter Jurisdictions in These Actions Pursuant to 28 U.S.C. §1331.

In each of these actions the Petitioners named as defendants not only the Secretary but also DPW, the state Medicaid agency. The relief granted by the District Courts

also enjoined DPW from discontinuing each of the Petitioners from Medicaid without a pre-termination hearing. Petitioners' theory against DPW involved the same federal constitutional and statutory challenges as against the Secretary but, in addition, it was argued that Indiana law independently required a hearing prior to termination from participation in the Medicaid Program. In Care Inns, only, DPW appealed the District Court's exercise of pendent jurisdiction.

The Seventh Circuit found that federal question jurisdiction pursuant to 28 U.S.C. §1331 (1976 & Supp. 1981) did not lie in these actions, and in support of this proposition again cited its own decision in *Northlake*, which itself was predicated on this Court's decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975). The Seventh Circuit held that *Salfi* established the principle that 42 U.S.C. §405(h) precluded the use of §1331 as a jurisdictional basis for challenging provider termination decisions. Having found §1361 mandamus jurisdiction inappropriate, and subject matter jurisdiction similarly unavailable under §1331 or 42 U.S.C. §405(g), the Court concluded that the District Court in Care Inns had abused its discretion by exercising pendent jurisdiction over the state defendants, citing *United Mine Workers of America v. Gibbs*, 383 U.S. 715 (1966).

The Seventh Circuit's holding is in conflict with *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 266 (3rd Cir. 1978) wherein it was held that the jurisdictional bar of 42 U.S.C. §405(h) did not preclude the exercise of subject matter jurisdiction pursuant to §1331 in an action in which an *independent violation* of due process rights is alleged against a state defendant. As noted above, all Petitioners herein stated claims against DPW premised upon DPW's violations of due process rights to which the Petitioners were entitled under the federal constitution, and also under

federal statutory law.[13] Each of the Petitioners were participants in Medicaid, and this Court has made no statement on whether constitutional and statutory challenges under Medicaid are foreclosed by 42 U.S.C. §405(h). In addition to the Third Circuit in *Town Court*, other circuits have found that §405(h) does not bar federal question jurisdiction for claims arising pursuant to 42 U.S.C. §§1396 *et seq.* See *Hadley Memorial Hospital, Inc. d/b/as Hadley Regional Medical Center, et al. v. Schweiker*, No. 80-1806, issued September 13, 1982, ___ F.2d ___, CCH Medicare and Medicaid Guide ¶32,153 (10th Cir. 1982). Furthermore, there is no provision in the Medicaid Act, 42 U.S.C. §§1396 *et seq.*, which carries the §405(h) jurisdictional limitations into that Act, in contrast to 42 U.S.C. §1395ii, which explicitly carries §405(h) into the Medicare Act. See *Califano v. Sanders*, 430 U.S. 99 (1976).

The Seventh Circuit failed to address petitioners' claims against DPW in its Opinion, thereby leaving the Petitioners to speculate on the validity of their claims against DPW. The Seventh Circuit's reliance on *United Mine Workers* is misplaced, since that case dealt with the presence of independent federal and non-federal claims. In the present actions, claims under federal law were articulated against both the Secretary and DPW. Petitioners' allegation that Indiana law also required a pre-termination hearing merely supplemented the federal claims against DPW. Thus, the Seventh Circuit's blanket dismissal of the Petitioner's actions against both the state

[13]The Court's attention is invited to §916(b)(1)(a), of the Omnibus Reconciliation Act of 1980 now codified at 42 U.S.C. §1396 a(i)(1981), which imposes upon state Medicaid agencies the same duties as are imposed upon the Secretary by 42 U.S.C. §1395cc(f), discussed under Question 1 of this Petition, *supra*.

and federal defendants is premature, and the District Court in Care Inns was correct in concluding that it could properly exercise pendent jurisdiction over DPW.

CONCLUSION

For these reasons, a Writ of Certiorari should issue to review judgment and opinion of the United States Court of Appeals for the Seventh Circuit, to clarify the rights and duties under §916 of the Omnibus Reconciliation Act of 1980 and to settle the conflicts among the several Circuit Courts of Appeal with regard to subject matter jurisdiction.

Respectfully Submitted,

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APPENDIX A

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 81-1522

AMERICANA HEALTHCARE CORPORATION, et. al.,
Plaintiffs-Appellees,

v.

RICHARD SCHWEIKER, Secretary of Health and Human Services,
Defendant-Appellant.

No. 81-2482

TURTLE CREEK CONVALESCENT CENTERS, INC. d/b/a NORTHSIDE HEALTHCARE CENTER,
Plaintiff-Appellee,

v.

RICHARD SCHWEIKER, Secretary of Health and Human Services
Defendant-Appellant.

No. 81-2755

CARE INNS, INC., d/b/a CLARKSVILLE HEALTHCARE CENTER,
Plaintiff-Appellee,

v.

ROBERT F. SMITH, Acting Administrator, DONALD L. BLINZINGER, Administrator of Indiana State Dept. of Public Welfare, and THE INDIANA DEPT. OF PUBLIC WELFARE,
Defendants-Appellants.

No. 81-2873
CARE INNS, INC., d/b/a CLARKSVILLE HEALTHCARE CENTER,
Plaintiff-Appellee,

v.

RICHARD SCHWEIKER, Secretary of the Department of Health and Human Services,
Defendant-Appellant.

No. 81-1507
LAURA HATHAWAY, d/b/a/ R.N. NURSING HOME, and JUDY CARROTHERS,
Plaintiffs-Appellees,

v.

RICHARD SCHWEIKER, Secretary of Health and Human Services,
Defendant-Appellant.

Appeals from the United States District Court for the Southern District of Indiana, Indiana Division.
No. 81-C-58—S. Hugh Dillin, *Judge.*
Nos. 81-C-172, 81-C-929—Cale J. Holder, *Judge.*
No. 80-C-1267—James E. Noland, *Judge.*

ARGUED MAY 3, 1982—DECIDED AUGUST 19, 1982

Before CUMMINGS, *Chief Judge*, COFFEY, *Circuit Judge*, and TEMPLAR, *Senior District Judge.**

COFFEY, *Circuit Judge*. Consolidated in this case are appeals from four separate orders of the United States

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*The Honorable George Templar, Senior District Judge for the United States District Court for the District of Kansas, is sitting by designation.

District Court for the Southern District of Indiana, Indianapolis Division.[1] Each of the orders appealed from granted the plaintiffs' request for injunctive relief prohibiting the defendants from terminating the plaintiffs' participation in the Medicare program and/or from terminating the payment of matching funds from Medicaid services without affording plaintiff an opportunity for a pre-termination hearing. We reverse.

The circumstances leading to the grant of injunctive relief in each case appealed from are set out below.

1. AMERICANA-ELKHART

Prior to October, 1980 Americana Health Care Center of Elkhart ("Americana-Elkhart") located in Elkhart, Indiana had been certified to participate in the Medicare program as a skilled nursing facility and had entered into a provider agreement with the U.S. Department of Health and Human Services (Department) for the provision of skilled nursing services to eligible patients.

The statutory requirements for participation in the federally funded Medicare program are set forth in Title 18 of the Social Security Act, 42 U.S.C. §1395 (1976 and Supp. IV, 1980). The U.S. Department of Health and Human Services administers this program which provides health insurance benefits for aged and disabled persons by making payments directly to the institution or individual providing the health service or care. 42 U.S.C. §1395cc(f) (1976 and Supp. III, 1980). In order to receive payment for services rendered to a Medicare patient, an institution must meet the conditions of participation prescribed by the Social Security Act and accompanying regulations. *See* 42

[1]Judge Cale J. Holder entered the orders appealed from in Appeals Nos. 81-2482, 81-2755, and 81-2783. Judge S. Hugh Dillin entered the order appealed from in Appeal No. 81-1522 and Judge James E. Noland entered the order appealed from in Appeal No. 81-1507.

U.S.C. §1395 (1976 and Supp. III, 1980) and 42 C.F.R. §405.1011 *et seq.* (1981).[2] If an institution meets the conditions of participation it then becomes eligible to execute and enter into a one-year renewal provider agreement with the United States Government. 42 U.S.C. §1395cc. (1976 and Supp. III, 1979). Institutions certified as Medicare providers are subject to periodic surveys by state agencies designated by the Secretary to evaluate compliance with federal standards.[3] 42 U.S.C. §1395aa (1976 and Supp. IV, 1980) and 42 C.F.R. §405.1904 (1981). If the institution fails to maintain compliance with the prescribed conditions of participation, a report of the survey is sent to the Secretary of the U.S. Department of Health and Human Services and the Secretary then has the authority to terminate the institution's provider agreement at any time or decline to renew the provider agreement at the close of the one-year period. 42 U.S.C. §1395cc(b)(2) (1976 and Supp. III, 1979) and 42 C.F.R. §489.53(a)(3) (1980).

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[2]There are 18 "conditions" that nursing homes are required to meet. Each condition relates to one broad aspect of the facilities' operations such as "medical direction" or "nursing services." Each condition of participation is divided into subparts known as "standards." Examples of standards include "coordination of medical care" or "rehabilitative nursing care". Standards are further broken down into elements, which are regulatory requirements such as "presence of marked spaces for parking by the handicapped," or the establishment of procedures for recording deviations in the patients food or fluid intake. A deficiency is a failure to comply with some "element" of a standard. When several elements are deficient a "standard" is not met and if enough standards are not met a finding is made that a facility does not meet a given "condition of participation."

[3]Pursuant to 42 U.S.C. §1395aa (1976 and Supp. IV, 1980) the Secretary of the U.S. Department of Health and Human Services is authorized to appoint a State health agency or other appropriate State agency (or local agencies) to conduct surveys of the skilled nursing facilities and inspect the physical plant and operational activities of the facility. In these consolidated cases the Indiana State Board of Health conducted the surveys made on behalf of the U.S. Department of Health and Human Services.

A letter dated October 22, 1980 from the U.S. Department of Health and Human Services notified Americana-Elkhart that an onsite survey conducted by the Indiana State Board of Health in August of 1980 demonstrated that Americana-Elkhart had deficiencies which "seriously limit your [their] capabilities to render adequate care and insure the health and safety of your [their] patients" and that the Department would not renew Americana-Elkhart's provider agreement with the Department which expired on December 1, 1980.[4] The Department's letter informed Americana-Elkhart that it could request that the Department through its subdivision, the Health Care Financing Administration, to reconsider its decision within 60 days of the notice.[5] The letter also requested that the Department be advised within 10 days of the notice if the listed deficiencies had been corrected.

Americana-Elkhart requested a reconsideration and an evidentiary pre-termination hearing of the Department's decision, asserting that it had corrected most of the deficiencies and asking that publication of notice of nonrenewal be deferred pending reconsideration. The Department denied the request for an evidentiary pre-

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[4] Attached to the Department's October 22, 1980 letter was a four page summary of the deficiencies found in the Americana-Elkhart facility.

Among the items listed in the Statement of Deficiencies was the finding that the facility did not meet the Nursing Services Condition of Participation due to deficiencies such as the lack of sufficient nurse staff coverage, and the lack of documentation that physician and medication orders were being followed. The statement of deficiencies also listed other deficiencies including but not limited to the finding that medications in the drug cart used in passing medications were not patient identified, therapeutic menus were not planned in writing, and patient medical records lacked physicians' progress notes at the time of their visits.

[5] A reconsideration is authorized by 42 CFR §405.1510-1519 (1981). During a reconsideration the Secretary or his appropriate agent reviews the findings on which the original decision was based and any new evidence submitted by the facility within a reasonable time and either affirms or revises the initial decision.

termination hearing but pursuant to Americana-Elkhart's request for reconsideration, a resurvey of the facility was conducted. On the basis of the resurvey results showing that the facility was still not in compliance with all Medicare conditions of participation, the Department reaffirmed its decision to deny renewal of Americana-Elkhart's provider agreement. After the resurvey the Department informed Americana-Elkhart of its decision and included with its letter a list of the facility's continuing deficiencies. In addition, the letter stated that the effective date of the nonrenewal would be extended until January 31, 1981 to allow adequate time for public notice to residents or their families to allow them to find alternative facilities in which they could receive care. Finally, the letter informed the facility of its right to request within 60 days an administrative hearing before an Administrative Law Judge.

42 C.F.R. §442.20(b) (1980) requires that a state Medicaid agency *must terminate* or refuse to renew a Medicaid agreement it has with a facility once the U.S. Department of Health and Human Services decides to terminate or refuse to renew a Medicare agreement with a skilled nursing facility.[6] Thus as a result of the U.S. Government's determination that Americana-Elkhart was not eligible for continued participation in the Medicare program the Indiana Department of Public Welfare

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[6] 42 CFR §442.20(b) (1981) provides:

§442.20 Additional requirements for agreements with SNF's participating in Medicare.

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(b) If the Secretary notifies the Medicaid agency that he has denied, terminated, or refused to renew a Medicare agreement with a SNF, the agency must deny, terminate, or refusal to renew its Medicaid agreement with that SNF. The denial, termination, or refuse to renew the Medicaid agreement must be effective on the same date as the denial, termination, or refusal to renew the Medicare agreement.

decertified the nursing home from participation in the Indiana Medicaid program.

On January 27, 1981 the plaintiffs brought this action in the federal district court alleging that the administrative procedures allowing for a post-termination hearing violated the Due Process Clause of the United States Constitution and the federal statutes. In addition, the complaint alleged that the U.S. Department of Health and Human Services' refusal to grant a pre-termination hearing made it an appealable final order of an administrative agency under 42 U.S.C. §405(g) (Supp. IV, 1980).

Following a hearing the district court granted a preliminary injunction prohibiting the U.S. Department of Health and Human Services and the Indiana Department of Public Welfare from terminating the plaintiff's participation in the Medicare and/or Medicaid program without a pre-termination hearing.[7]

2. AMERICANA-MIDTOWN

Americana Health Care Center of Indianapolis-Midtown (Americana-Midtown) was another certified skilled nursing facility participating in the Medicare program prior to October, 1980. By letter dated October 24, 1980 the U.S. Department of Health and Human Services notified Americana-Midtown that based upon the results of an onsite survey conducted from August 25 to 29, 1980 it had been determined that Americana-Midtown had deficiencies that "seriously limits your [their] capability to render adequate care and insure the health and safety of your [their] patients" and thus the Department would not renew

[7]Americana Health Care Corporation owns both the Americana-Elkhart facility and the Americana-Midtown facility. Because of this identity of ownership the Americana Health Care Corporation brought its challenge to the pre-termination procedures applied by the U.S. Department of Health and Human Services in both the Americana-Midtown and Americana-Elkhart cases in a single action.

its provider agreement with Americana-Midtown which was scheduled to end December 1, 1980. Attached to the letter was a four-page statement of deficiencies which formed the basis for the nonrenewal.[8].

The U.S. Department of Health and Human Services letter also informed the facility of its right to request that the Department reconsider its decision. Americana-Midtown requested reconsideration contending that it had corrected the majority of the alleged deficiencies. The Indiana State Board of Health as agent of the U.S. Department of Health and Human Services conducted a resurvey of the facility and based upon the results of that resurvey reaffirmed its original decision not to renew Americana-Midtown's provider agreement but extended the effective date of the nonrenewal to January 31, 1981 to allow adequate time for public notice to allow the transfer of patients to an eligible and certified facility. The Department informed the facility of its decision by letter detailing the deficiencies of the nursing home and informing the plaintiff of its right to request a hearing within 60 days. In addition to the request for a resurvey, the plaintiff also requested that the defendant conduct a pre-termination evidentiary hearing which request was subsequently denied by the U.S. Department of Health and Human Services.

In accordance with the provisions of 42 C.F.R. §442.20(b) the Indiana Department of Public Welfare also decertified Americana-Midtown as a Medicaid provider based upon the Department of Health and Human Services nonrenewal decision and the facility's deficiencies.

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[8]Among the listed deficiencies were the following: insufficient nurse staff coverage, rehabilitative nursing care services not performed daily, treatments being performed either without physicians' orders or not according to such orders, lack of a clean interior, ineffective asceptic procedures, and food not stored, prepared or served under sanitary conditions.

On January 27, 1981 this action was filed in the district court seeking to enjoin the Department of Health and Human Services and the Indiana Department of Public Welfare from enforcing the nonrenewal decision against both Americana-Midtown and Americana-Elkhart.[9] The district court granted the preliminary injunction, holding that the plaintiffs had shown that they would suffer irreparable harm if injunctive relief was not ordered pending resolution of the question of the plaintiffs' entitlement to a pre-termination hearing.[10]

3. TURTLE CREEK CONVALESCENT CENTERS, INC.

On November 3 through 7, 1980 an annual survey was conducted by the Indiana State Board of Health of the Turtle Creek Convalescent Centers' nursing home facility known as the Northside Healthcare Center. The

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[9]See footnote 8 regarding the common ownership of the two facilities.

[10]During the preparation of this opinion the court received notice that both Americana-Midtown and Americana-Elkhart have been recertified for Medicare participation effective April 27, 1982 and April 29, 1982 respectively. Upon receipt of this notice the court requested that the parties submit a statement on whether the issues on appeal are moot in view of the recertification. After consideration of the statements of the parties, including the plaintiffs' response to the government's statement, submitted pursuant to our request we determine that the issues raised by the appeal in #81-1522 *Americana Healthcare Corp. v. Schweiker* are not moot because resolution of the issues presented herein is necessary to a proper determination of the question of whether the nursing facility was validly decertified during the period extending from the date of the initial decertification until the date of effective reinstatement. In its statement to the court on the question of mootness the U.S. Department of Health and Human Services raised for the first time the question of its right to recover payments made to the Americana Healthcare facilities during the pendency of this appeal. Because neither party has argued or briefed the issue of the government's right to recover the Medicare payments, we decline to reach this issue on appeal. Further, the resolution of the issues presented herein serves the public interest by resolving an issue which otherwise is likely to recur, that is the question of entitlement to pre-termination hearings and the limitations on district court review of decertification decisions prior to an agency's "final decision."

Department of Health and Human Services concluded, based upon the survey done at its request, that the survey results demonstrated that the nursing home had deficiencies that "seriously limit your [their] capability to render adequate care and insure the health and safety of your [their] patients." Based upon the deficiencies revealed during the survey the Department decided not to renew the plaintiff's provider agreement which was scheduled to end March 1, 1981. The Department informed the plaintiffs of its decision by means of a letter dated January 22, 1981. The letter listed the deficiencies found during the survey and informed the facility of its right to request reconsideration of the nonrenewal decision.[11]

Turtle Creek requested reconsideration of the decision not to renew the provider agreement. Pursuant to the request for reconsideration the Department attempted to conduct a resurvey of the facility on February 9, 1981. The resurvey, however, was not completed when Turtle Creek's administrator objected and requested that the survey be discontinued after he was informed that the resurvey results would be based upon records of patient care kept before the date of the first survey as well as those kept thereafter. Despite the fact that the reconsideration survey was not completed, the inspectors determined that the facility was still not in compliance with the conditions for continued participation in the Medicare program.

Turtle Creek, like the other plaintiffs in this case, requested that the U.S. Department of Health and Human Services conduct an evidentiary pre-termination hearing which request was denied by the Department.

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[11]Among the deficiencies listed by the Indiana State Board of Health were the following: nursing services not being provided to patients in need of such services, no active rehabilitation program in feeding, bladder training, ambulation and self-care services, patient records lacked pertinent information regarding patient condition, assessment, and treatment, and presence of unsanitary conditions relating to dietetic services.

Pursuant to the mandatory requirements of 42 C.F.R. §442.20(b) the Indiana Department of Public Welfare decertified Turtle Creek as a provider under the Indiana Medicaid program, upon receiving notice of the U.S. Department of Health and Human Service's decision not to renew Turtle Creek's provider agreement.

Prior to the effective date of the nonrenewal decision, Turtle Creek brought this lawsuit alleging that the failure of the state and federal agencies to afford Turtle Creek a hearing prior to termination from both the Medicare and Medicaid programs violated Turtle Creeks' constitutional right to due process as well as federal and state statutes. Turtle Creek sought injunctive relief prohibiting the termination of Turtle Creek's participation in the Medicare and Medicaid Programs without a pre-termination hearing.

The court granted a temporary restraining order on the date the complaint was filed and scheduled a bench trial to commence shortly thereafter. At the conclusion of trial the court entered a permanent injunction prohibiting the defendants from decertifying Turtle Creek's facility relating to any decertification proceeding initiated prior to the date of the injunction and further enjoining the defendants from decertifying the Turtle Creek nursing home in any subsequent proceeding until such time as the defendants accord Turtle Creek a pre-termination evidentiary hearing.

The district court based this order upon its finding that it had jurisdiction over the parties pursuant to 28 U.S.C. §1331(a) and §1361 (1976 and Supp. IV, 1980) and the administrative appeal provisions of 5 U.S.C. §701 and §705 (1976). The court also held that a pre-termination hearing was required under the provisions of the Omnibus Reconciliation Act of 1980, P.L. 96-499, §916(b)(2) amending §1910 of the Social Security Act, 42 U.S.C. §1320(a)(1) (Supp. IV 1980). The court further found that

no emergency existed in any area that would require the immediate termination of participation in the Medicare-Medicaid programs and that the failure to accord the plaintiff a pre-termination hearing was a violation of Turtle Creek's right to due process under the law.

4. CARE INNS, INC.

On May 11 through 14, 1981 an onsite survey was conducted at the Clarksville Healthcare Center, a Medicare skilled nursing facility owned by Care Inns, Inc. Based upon the results of this survey demonstrating that the facility failed to comply with Medicare conditions of participation and based upon a prior plan of corrections submitted by Care Inns on June 5, 1981, in response to the notice of deficiencies in the facility received at the time of the survey, the U.S. Department of Health and Human Services refused to renew Care Inns' Medicare provider agreement that was scheduled to terminate on September 1, 1981.[12] The Department notified Care Inns of this decision by letter dated July 22, 1981 in which the Department further informed Care Inns that the results of the survey showed that the facility had deficiencies which seriously limited the facility's capability to render adequate care and "immediately jeopardized the health and safety of the patients." Attached to the letter was a six-page statement listing the deficiencies found during the survey. The letter also informed Care Inns of its right to request reconsideration of the nonrenewal decision and of the possibility that Department officials would meet with representatives of the facility to discuss the survey findings prior to the nonrenewal deadline.

[12]The statement of deficiency listed, among other items, the following: instances when proper nursing care was not being provided to patients in need of such care, treatment and medication being administered contrary to physicians' orders, supervision of nursing services inadequate, failure to notify physician in case of patient with recent leg amputation having pain, presence of unsanitary conditions relating to dietetic services, required medications frequently unavailable, and no written procedures for preventing spread of infection from linens and dressings.

Care Inns requested a resurvey and responded to the cited deficiencies contending that the facility was now in compliance with all Medicare conditions of participation. Pursuant to Care Inns' request a resurvey of the facility was conducted on August 10 and 11, 1981. The resurvey demonstrated that in several respects the facility continued to fail to provide the proper and required nursing care to its patients. In addition to the resurvey a meeting was held between Care Inns' representatives and officials of the U.S. Department of Health and Human Services in which Care Inns was afforded an opportunity to respond to the resurvey findings and submit new evidence of compliance.

At the time the plaintiff requested a resurvey it also requested a pre-termination evidentiary hearing which request was denied by the defendant.

On August 31, 1981 Care Inns filed this action in the district court making substantially the same allegations as contained in the Americana and Turtle Creek complaints. By agreement of the parties a bench trial on the merits was consolidated with the preliminary injunction hearing. The district court, in its findings of fact and conclusions of law held that, in fact, "no emergency" existed at the time of the survey justifying the Department's refusal to afford a pretermination hearing. The court further held that the Department's decision not to renew the provider agreement was an appealable final order of an administrative agency under 5 U.S.C. §701 and §705. The court held that its subject matter jurisdiction over the case existed under 28 U.S.C. §1331(a) (federal question jurisdiction) and in fact the failure of the defendants to afford a pre-termination hearing violated the provisions of the federal Omnibus Reconciliation Act of 1980 §916(a).

In the alternative, the court concluded that both the federal and state defendants failed to provide the plaintiff with a hearing in violation 42 U.S.C. §402(g) and/or the Indiana Administrative Adjudication Act. Based upon

these holdings the court granted the requested injunction and prohibited the defendants from enforcing the nonrenewal sanction for the year September 1, 1981 through August 31, 1982.

5. R.N. NURSING HOME

The Indiana Department of Public Welfare notified the R.N. Nursing Home (R.N.) by letter dated December 4, 1979 that it was going to be decertified as a Medicaid intermediate care facility because it failed to comply with the conditions of participation in that program. The Indiana Department's action was based upon the results of a survey conducted at the home which revealed numerous deficiencies in the facility. The letter sent by the Indiana Department of Public Welfare notified the facility that it had 15 days to file written objections to the decision and to request an administrative redetermination.

Subsequently, R.N. Nursing Home requested the Indiana Department of Public Welfare to hold a hearing prior to any decertification action. Upon agreement of the parties this hearing was postponed pending the outcome of a state licensure proceeding involving R.N.'s state nursing home license. The licensure proceedings were completed on August 18, 1980 with a recommendation that the home be accorded a full license.

On September 23, 1980 the Regional Medicaid Director of the Federal Health Care Financing Administration notified the Indiana Department of Public Welfare by a letter that the state's claim for federal matching funds for Medicaid payments made to R.N. Nursing Home was being recommended for deferral because of the determination that R.N. was not in compliance with the Medicaid intermediate care facility conditions of participation.[13]

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[13]The deficiencies found during the survey are not recited in the record on appeal.

Under Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.* (1976 and Supp. IV, 1980) the Medicaid program is established as a cooperative federal-state program to provide payments for "necessary medical services" rendered to needy individuals. A state is not required to institute a Medicaid program; however, if it chooses to do so it must submit a satisfactory state plan to the U.S. Department of Health and Human Services. The U.S. Department then reviews the plan and if a state plan is approved the state becomes entitled to federal grants reimbursing the state for a portion of the expenditures which it makes to qualified healthcare facilities for providing medicaid services to qualified individuals.

Under 42 U.S.C. §1396(a)(33)(B) (1976) the states are responsible for determining whether or not a state facility complies with the federal requirements of participation as a Medicaid intermediate care facility.[14] Once the facility has been so certified the state Medicaid agency (here the Indiana Department of Public Welfare) may execute a provider agreement with the facility for the provision of services and making of payments under the state plan. The state may not obtain federal reimbursement of expenditures made for services rendered in a facility which has not been certified as meeting federal requirements of participation and which lacks a valid provider agreement.

Under Medicaid the U.S. Department of Health and Human Services does not pay nursing homes directly for the federal government's share of services they have rendered to eligible Medicaid recipients. Rather, the Medicaid payment procedure, set out in 42 U.S.C. §1396b(d) (1976 and Supp. IV, 1980) requires the Secretary of the U.S. Department of Health and Human Services to

[14] An intermediate care facility is one kind of medical service which a state may provide under its Title XIX plan. Other types of services such as those provided by a skilled nursing facility can be provided under Medicaid.

estimate the amount due the state for the payments it has made to Medicaid providers based upon the state's report of its expenditures and "such other investigation as the Secretary may find necessary" and adjusted to reflect, *inter alia*, any prior overpayment or underpayment "which the Secretary determines was made for any prior quarter." 42 U.S.C. §1396b(d)(1), (2). Based on these factors the Secretary then issues a grant award to the state.

A determination by the Secretary that expenditures claimed by the state do not meet federal requirements and, hence, are not reimbursable with federal funds is called a "disallowance." *See* 42 U.S.C. §1316(d); 45 C.F.R. §201.14(a), (d), as amended (1981).

42 U.S.C. §1316(d) (1976) provides for an administrative reconsideration of the disallowance of Title XIX funds to a state:

> Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under...(Title XIX) shall be disallowed for such participation, the state shall be entitled to and upon request shall receive a reconsideration of the disallowance.

42 U.S.C. §1316(d).

Even before a disallowance the Department may defer a decision on the allowability of claims submitted by a state until further evidence is submitted. 45 C.F.R. §201.15 *et seq.* (1981). The regulations allow the administrator or designate of the Health Care Financing Administration of the U.S. Department of Health & Human Services to defer claims only when the administrator "believes the claim or specific portion is of questionable allowability." 45 C.F.R. 201.15(c)(1). After a deferral action is taken, the state is given an opportunity to provide documentation concerning the proposed disallowance of the claim. 45 C.F.R. §201.15(c)(2). After all documentation has been received, the Administrator has 90 days to determine the propriety

of allowing of the claim. 45 C.F.R. §201.15(c)(6). If the U.S. Department disallows the claim the state is given a written notification of the disallowance decision, 45 C.F.R. §201.15(c)(8), and is permitted another administrative appeal pursuant to 45 C.F.R. §201.14. 45 C.F.R. §201.15(c)(9).

Thus in this case the Federal Healthcare Financing Administration deferred payment of Federal Matching Funds to the Indiana Department of Public Welfare because of the pending decertification action brought by the Indiana Department.

Subsequently, the Indiana Department of Public Welfare, by a letter dated December 19, 1980, notified R.N. that based upon the Department's interpretation of the relevant Indiana law (Indiana Code 12-1-7-14.9(b)) it was required to defer any payment to the nursing home because federal financial participation was no longer approved and available to the facility. According to the plaintiffs this action was taken without a proper hearing on the question of the termination decision.

The plaintiffs then brought this action seeking a temporary restraining order prohibiting the defendants from discontinuing the reimbursement of R.N. for Medicaid intermediate care services. The plaintiffs alleged that they were entitled to a pre-termination hearing pursuant to 5 U.S.C. §701 *et seq.*, §916(b)(2) of the Omnibus Reconciliation Act of 1980, P.L. 96-499 and this court's decision in *Hathaway v. Mathews*, 546 F.2d 227 (7th Cir. 1976). On December 31, 1980, the district court temporarily restrained the defendants from terminating reimbursement for services rendered by R.N. and the parties subsequently agreed to continue the temporary restraining order pending a hearing. The district court on January 27, 1981 ordered that the December temporary restraining order remain in full force and effect pending further order but permitted new administrative proceedings if any new basis for decertification was found.

On March 9, 1981, the Indiana Department of Public Welfare petitioned the district court to amend its temporary restraining order to permit the removal of patients from the home pursuant to a subsequent decertification action. The court denied this petition on March 19, 1981, holding that the subsequent decertification action was interrelated to the pending action and therefore was more in the nature of a "continued" decertification action than a new action and thus came within the parameters of the prohibitions recited in the temporary restraining order.

ISSUES

(1) Did the district courts have subject matter jurisdiction of each of the consolidated cases?

(2) Did the district courts properly exercise pendent jurisdiction over the state claims in the Care Inns case?

SUBJECT MATTER JURISDICTION

A. FEDERAL QUESTION JURISDICTION

In each of the consolidated cases the defendants challenged the courts' subject matter jurisdiction over the action. The district courts in each instance rejected this argument holding that subject matter jurisdiction existed based upon either Federal Question jurisdiction, 28 U.S.C. §1331, Social Security Act Appeal jurisdiction, 42 U.S.C. §405(g), Federal Mandamus jurisdiction, 28 U.S.C. §1361, or Administrative Appeals jurisdiction, 5 U.S.C. §701 *et seq.*[15]

We must begin our analysis by pointing out that the holdings of the district courts in each of these cases

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[15]In this appeal the plaintiffs no longer continue to assert that subject matter jurisdiction exists under the provisions of 5 U.S.C. §701 *et seq.* The decision of the United States Supreme Court in *Califano v. Sanders*, 430 U.S. 99 (1976) establishes that in fact no such subject matter jurisdiction exists under the Administrative Procedure Act. *Id.* at 107.

predated the decision of this court in *Northlake Community Hospital v. United States of America*, 654 F.2d 1234 (7th Cir. 1981) in which the question of the district court's subject matter jurisdiction over actions challenging the termination of Medicare and/or Medicaid provider agreements was specifically addressed and the district courts were thus without the benefit of that opinion.

Northlake was an appeal from a dismissal of a suit for injunctive relief brought by the Northlake Hospital seeking to prohibit the U.S. Department of Health and Human Services from terminating the hospital's Medicare provider agreement without first affording it a pre-termination administrative hearing. This court began its analysis of the district court's dismissal of the lawsuit for lack of subject matter jurisdiction by recognizing that consistent with the United States Supreme Court's decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975), 42 U.S.C. §405(h) precludes the use of 28 U.S.C. §1331 as a jurisdictional basis for challenging Medicare provider termination decisions.

> In *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Services*, 570 F.2d 660 (7th Cir. 1977), this court agreed that *Salfi* 'precludes the use of 28 U.S.C. §1331 as a jurisdiction basis' for Medicare provider reimbursement disputes. Although Northlake's claim in the instant case involves the procedures for terminating a provider agreement rather than the procedures for obtaining reimbursement pursuant to such an agreement, the result with respect to these two procedures should be the same. Under *Salfi* and *Trinity*, Northlake's allegation of federal question jurisdiction is defective.

Northlake, 654 F.2d at 1240.

This holding is applicable to the cases at bar and precludes the district court from establishing subject matter jurisdiction over the cases based upon federal question jurisdiction.

B. JURISDICTION UNDER 42 U.S.C. §405(g)

The court continued its analysis in *Northlake* and considered whether subject matter jurisdiction was conferred upon the district courts by 42 U.S.C. §405(g). It was recognized that Title XVIII of the Social Security Act specifically states that an institution dissatisfied with a final decision of the Secretary of the Department of Health and Human Services to terminate its Medicare provider agreement may obtain judicial review of the decision pursuant to 42 U.S.C. §405(g). 42 U.S.C. §1395ff(c). However, the court noted that §405(g) permits review only where the three requirements set forth therein have been complied with:

> Under the terms of Section 405(g), review is available only if three requirements have been satisfied: (1) an action was brought 'after any final decision of the Secretary made after a hearing to which [the provider] was a party;' (2) the action was commenced within 60 days after the mailing of the notice of decision by the Secretary or within such time as the Secretary may allow; and (3) the action was filed in an appropriate court. 42 U.S.C. §405(g) (1979).

Northlake 654 F.2d at 1240.

This court then pointed out that the Supreme Court in its *Salfi* opinion held that the first requirement of §405(g) jurisdiction is a final decision by the Secretary after a hearing and this first requirement is "central to the requisite grant of subject-matter jurisdiction" *Salfi*, 422 U.S. at 764. In the cases consolidated in this appeal, as well as in *Northlake*, the plaintiff Medicare-Medicaid providers did not exhaust their available administrative remedies prior to the filing of these lawsuits and thus have not received the "final decision" of the Secretary required for 42 U.S.C. §405(g) jurisdiction.

The plaintiffs in the case at bar argue, however, as did

Northlake Hospital, that they fall within an exception to the final decision requirement.

In *Mathews v. Eldridge*, 424 U.S. 319 (1976) the Supreme Court found that there are two prerequisites to a final decision under §405(g). The first of these prerequisites is the presentation of a claim for benefits. This element is nonwaivable and absent such a claim there can be no appealable decision of any type. *Id.* at 329. In each of the cases at bar the parties challenge the decision to terminate their provider status along with challenging the administrative body's failure to allow them a pre-termination hearing and thus they have satisfied this element.

The second prerequisite to a "final decision" under §405(g) set forth in *Mathews*, 424 U.S. at 329 requires the exhaustion of administrative remedies and this element is waivable by the Department of Health and Human Services. *Id.* at 328. In addition to being waivable by the Department the decision of the United States Supreme Court in *Mathews* establishes that this exhaustion requirement may also be waived where the plaintiff raises a colorable constitutional challenge which is entirely collateral to his claim of entitlement and the claimant's interest in having this issue resolved is so great as to make deference to the agency's judgment inappropriate. *See Mathews*, 424 U.S. at 331, 332; *Northlake*, 654 F.2d at 1243.

In the instant cases as in *Northlake* the plaintiffs argue that the alleged due process violation arising out of the failure to afford a pre-termination hearing constitutes a colorable constitutional claim sufficient to permit a waiver of the exhaustion prerequisite of §405(g). Similar agruments regarding constitutional entitlement to a pre-termination hearing under the due process clause were specifically rejected by this court in *Northlake*, 654 F.2d at 1241-1243 and the rationale of that opinion rejecting the constitutional due process claim is equally applicable to the cases consolidated in this appeal.

Each of the plaintiffs in the cases consolidated herein was afforded advance notice of the decision to decertify their respective facility as a Medicare and/or Medicaid provider. In addition, each was informed of the deficiencies upon which the decision to decertify the facility was based and was afforded an opportunity for a resurvey to demonstrate any corrections made in the listed deficiencies and each was permitted to submit documentation explaining or refuting the existence of the deficiencies. In the case of Care Inns, Inc. the facility was also permitted to meet with personnel of the Department of Health and Human Services and submit evidence of compliance with applicable conditions of participation prior to termination. Weighing the benefits of these procedural protections, the interest in efficient and not unduly expensive administrative procedures as well as the strong government interest in the protection of Medicare and Medicaid recipients against the risk that a facility will be erroneously terminated as a Medicare or Medicaid provider, we conclude that the plaintiffs have failed to establish a colorable claim of constitutional entitlement to a pre-termination hearing.

The plaintiffs have argued that the prior decision of this court in *Hathaway v. Mathews*, 546 F.2d 227 (7th Cir. 1976) supports the contrary conclusion that the plaintiffs are constitutionally entitled to a pre-termination hearing.[16] The *Hathaway* decision predated the later *Northlake* decision and was factually distinguished in a footnote therein. 654 F.2d at 1243 n.10. In *Hathaway* the Medicaid facility was terminated from the Medicaid program by the U.S. Department of Health and Human Services acting independent of the state Medicaid agency and it did not receive notice of the alleged deficiencies, nor was a post-termination hearing available to it under the applicable

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[16]Initially it can be pointed out that the *Hathaway* decision did not address the question of jurisdiction which is the basis of both the *Northlake* and the present opinion.

regulations. This is contrasted with the fact situations presented here, wherein each of the plaintiffs received written notice of the alleged deficiencies and had post-termination procedural protections available to them. To the extent that *Hathaway* remains good law within the circuit it is limited to its unique factual situation, including a lack of prior notice of deficiencies from the terminating agency and the absence of post-termination appeal procedures.

Laura Hathaway, plaintiff in case No. 81-1507 consolidated in this appeal, specifically argues that the facts of her case more nearly resemble those of the earlier *Hathaway* decision than those of *Northlake*. The *Hathaway* case consolidated in this appeal differs from the earlier *Hathaway* decision, however, because in the case at bar the facility was decertified initially by the state Medicaid agency acting on its own rather than on behalf of the U.S. Department of Health and Human Services and it had procedures available to it through which it could challenge the state's determination. In addition, the federal Department of Health and Human Services merely *deferred* reimbursement to the state for services rendered by R.N. Nursing Home pending resolution of the decertification question. The fact that the state Medicaid agency failed to challenge the deferral of repayment does not provide the home with a colorable constitutional claim upon which it could assert jurisdiction in a federal court.

In light of our holding that the plaintiffs have not presented a colorable constitutional claim to a due process pre-termination hearing, we conclude that the district courts in the present action did not have subject matter jurisdiction over the consolidated cases pursuant to 42 U.S.C. §405(g).

C. MANDAMUS JURISDICTION

In the alternative, the plaintiffs have asserted that the district courts had mandamus jurisdiction over the cases

consolidated in this appeal pursuant to the provisions of 42 U.S.C. §1361. Plaintiffs contend that §916 of the Omnibus Reconciliation Act of 1980, P.L. 96-499 creates a clear right to a pre-termination hearing and thus the exercise of mandamus jurisdiction on the part of the district courts was proper.

The defendants respond to these arguments by contending that 42 U.S.C. §405(h)[17] is intended to preclude the exercise of mandamus jurisdiction in the same manner as it precludes the exercise of federal question jurisdiction over decisions appealable under the provisions of the Social Security Act. They argue that consistent with principles of statutory construction §405(h) should be read as encompassing the statutory addition of mandamus jurisdiction within the jurisdictional exclusions of §405(h).

The defendants further argue that §916 of the Omnibus Reconciliation Act does not create a clear right to a pre-termination hearing under the facts of these cases even if the district courts are entitled to exercise mandamus jurisdiction over the decisions made under the Social Security Act and thus the exercise of mandamus jurisdiction in these consolidated cases was inappropriate.

Independent of the question of whether §405(h) bars mandamus jurisdiction in cases brought under the provisions of the Social Security Act, it is well established in case law that mandamus jurisdiction may be invoked only where the following three elements are present:

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[17] 42 U.S.C. §405(h) provides:

Finality of Secretary's decision. The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

> Mandamus may properly issue only when three elements are present:
>
> (1) a clear right in the plaintiff to the relief sought;
>
> (2) a plainly defined and peremptory duty on the part of the defendant to do the act in question;
>
> (3) no other adequate remedy available.

Lovallo v. Froehlke, 468 F.2d 340, 343 (2nd Cir. 1972). *Cervoni v. Secretary of Health, Education and Welfare*, 581 F.2d 1010, 1019 (1st Cir. 1978).

Regarding the first of these elements it is also established that the mandamus remedy is only available "under exceptional circumstances of clear illegality." *Id.* at 1019.

> When the performance of official duty calls for a construction of governing law, the [federal] officer's interpretation will not be disturbed by a writ of mandamus unless it is clearly wrong and his official action is arbitrary and capricious.

Association of American Medical Colleges v. Califano, 569 F.2d 101, 110 n.80 (D.C. Cir. 1980).

The plaintiffs in the cases consolidated in this appeal assert that recent changes made in the Social Security Act by §916 of the Omnibus Reconciliation Act of 1980, P.L. 96-499 established their clear right to a pre-termination hearing. Specifically the plaintiffs contend that subpart (a) of §916 is applicable to the case at bar. That section provides:

> ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY
>
> SEC. 916. (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

"(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

The plaintiffs argue that subpart 2 of the new subsection requires a hearing prior to the date of any termination or decertification of a Medicare skilled nursing facility.

The plaintiffs' interpretation of subpart 2 is based upon their conclusion that the phrase "such a decision" refers to the Secretary's determination of whether the facility's deficiencies "immediately jeopardize the health and safety" of the patients. This construction of subpart 2 is

essential to the plaintiffs' interpretation of the statutory provision because a construction of the phrase "such a decision" as applying solely to the Secretary's decision in subpart (1)(B) of whether to impose an alternative sanction would require a pre-termination hearing only in those situations where the Secretary determines that the facility's deficiencies do not "immediately jeopardize" the health and safety of the patients. In each of the cases consolidated in this appeal in which the Secretary determines that a facility did not substantially meet the Medicare conditions of participation the Secretary concluded that a situation of "immediate jeopardy" existed.[18]

To construe the phrase "such a decision" in the manner in which the plaintiff asserts is appropriate leads one to the anomalous situation of permitting a skilled nursing facility to continue treating patients under conditions which the Secretary has concluded place the patients' very health and safety in "immediate jeopardy" while the facilities are afforded a time consuming pre-termination hearing. It is ludicrous to believe that the legislature intended to permit the appeal procedures to act as a roadblock to the prompt removal of patients for their own protection and safety from substandard facilities.

The plaintiffs argue that the need for haste in terminating a skilled nursing facility is not a purpose of the new provision because considerable delay occurs under the present procedure during the resurvey and notice period.

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[18]In the cases of Americana-Elkhart, Americana-Midtown, and Turtle Creek the Secretary's letter to the facility used the phrase "seriously limit your [their] capability to render adequate care and insure the health and safety of your [their] patients" when informing the facility that it did not substantially meet the Medicare conditions of participation. This phrase is interpreted as being equivalent to a finding of "immediate jeopardy." The brief of all the plaintiffs to this appeal conceeds as much in Footnote 10 of their brief in which they argue that the Secretary's determination of "immediate jeopardy" is not substantiated by the record.

The existence of this time-lag does not justify further delay in termination or nonrenewal but merely supports our earlier conclusion that the current procedures already afforded the plaintiffs more than adequate due process.

The plaintiffs' construction of the phrase "such a decision" is also inconsistent with the use of the mandatory term "shall" in subsection (1)(a) of the provision. The use of the mandatory term "shall" requires the termination sanction in cases where the conditions of "immediate jeopardy" to health and safety are found to exist.

Thus we conclude that a common sense reading of the statutory provision leads to the conclusion that a pre-termination hearing is not required where the Secretary determines that a situation of "immediate jeopardy" exists.

The limited legislative history available concerning the code provisions added by §916 of the Omnibus Reconciliation Act supports our interpretation of the legislation. The House Report on Public Law 96-499 explains that the purpose of the new Code provisions was to provide an alternative sanction to termination in cases where "immediate jeopardy" to patients' health and safety did not exist:

> At present, the only sanction available in many jurisdictions to penalize a skilled nursing facility which is out of compliance with the conditions of participation in the Medicare and Medical [sic] programs is to terminate that facility's participation in the program. Frequently, this sanction involves an overriding hardship to program beneficiaries which makes its use desirable [sic], if not impossible
>
> * * *
>
> In the case of facilities that are substantially out of compliance but do not have deficiencies that immediately jeopardize the health and safety of their patients, the section gives the Secretary authority to

> impose an intermediate sanction, short of the more drastic step of program termination.
>
> * * *
>
> Under the provision, a facility would have an opportunity to develop and implement a plan for correcting its deficiencies, in accordance with existing Medicare policies on the correction of provider deficiencies. Following the facility's failure to satisfactorily meet this requirement, the Secretary could apply intermediate sanctions, but only after the Secretary has provided the facility with an opportunity to present its case at an informal hearing consistent with current practices. If the facility seeks further administrative or judicial appeals, the sanction would remain in effect while the appeals were pending.

House Report No. 96-1167, reported in (1980), U.S. Code, Cong. & Ad. News, 96th Congress 2d Sess. 5569.

Later in that same report, however, it is made clear that the prompt termination sanction was intended to remain applicable in cases of "immediate jeopardy."

> [T]he committee believes that this sanction should not be used as an alternative in situations where a noncomplying facility's deficiencies place the health and safety of its patients in immediate jeopardy; instead, the response for the Secretary in such cases must be to deny all reimbursement of additional patients and to make appropriate arrangements for the orderly, planned transfer of existing patients.

Id. at 5570.

The legislative history and plain language of §916(a) of the Omnibus Reconciliation Act mandate the conclusion that the Code provision does not create a clear right on the part of the plaintiffs to a pre-termination hearing in situations where the Secretary determines that the facility's deficiencies placed the patients' health and safety in "immediate jeopardy."

The plaintiffs argue that several of the district courts found that, in fact, no situation of "immediate jeopardy" or emergency existed. This factual conclusion is more appropriately deferred to the expertise of the licensing agency and it is not a proper consideration for a court under mandamus jurisdiction where a clear right to a pre-termination hearing is required and a federal officer's interpretation "will not be disturbed unless it is clearly wrong." *Association of American Medical Colleges v. Califano*, 569 F.2d at 110 n.80.

Deference to the expertise of professionals who are trained and experienced in evaluating the compliance of Medicare or Medicaid facilities with federal regulations is consistent with recent decisions of the United States Supreme Court cautioning against a substitution of a judge's opinion for that of a professional. Most recently in *Youngberg v. Romeo*, 50 U.S.L.W. 4681 (U.S. June 18, 1982) the Court made the following comments regarding deference to a professional's opinion as to appropriate patient care:

> In determining what is "reasonable"—in this and in any case presenting a claim for training by a state—we emphasize that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions. See *Parham v. J.R.*, 442 U.S. 584, 607 (1979); *Bell v. Wolfish, supra*, 441 U.S. at 544 (Courts should not "'second-guess the expert administrators on matters on which they are better informed.'").

50 U.S.L.W. at 4684-85.

Absent a clear right to a pre-termination hearing, mandamus jurisdiction is not appropriate in the

consolidated cases in this appeal and thus we hold that the district courts were without jurisdiction over these cases.[19]

Because we determine that no clear right existed entitling the plaintiffs to a pre-termination hearing, it is not necessary to determine whether 42 U.S.C. §405(h) precludes mandamus jurisdiction as well as federal question jurisdiction in these cases.

PENDENT JURISDICTION

The sole issue remaining for our consideration is whether the district court in the Care Inns case properly exercised pendent jurisdiction when it determined that the Indiana Administrative Adjudication Act requires a hearing prior to the Indiana Department of Public Welfare's termination of a provider of skilled and intermediate nursing services from participating in the Medicaid program. It is axiomatic that "pendent jurisdiction is a doctrine of discretion, not of plaintiff's right." *United Mineworkers of America v. Gibbs*, 383 U.S. 715, 726 (1966). Further it is established that a federal court may exercise pendent jurisdiction only where there exists a federal claim of "substance sufficient to confer subject matter jurisdiction on the court." *Id.* at 725.

In light of our holding that the district courts were without subject matter jurisdiction over the cases consolidated in this appeal, it is equally clear that the district court could not exercise pendent jurisdiction over the state claim concerning entitlement to a pre-termination hearing under the relevant Indiana Code provisions. Thus the orders of the district court entered in these consolidated cases are REVERSED.

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[19]The arguments of plaintiff Laura Hathaway to the effect that she is entitled a pre-termination hearing under the "look behind" provisions of §916(b)(2) of the Omnibus Reconciliation Act are also rejected because the decision to decertify was initially made by the state Medicaid agency and the argument that the decertification action was subsequently abandoned is belied by the state's continuing efforts to decertify the facility. See the State's Emergency Petition to Amend the Court's Entry of January 27, 1981 dated March 9, 1981.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

AMERICANA HEALTHCARE CORPORATION; ELKHART AMERICANA, INC., d/b/a AMERICANA HEALTHCARE CENTER OF ELKHART; CAPITOL AMERICANA, INC., d/b/a AMERICANA HEALTHCARE CENTER OF INDIANAPOLIS—MIDTOWN,	)	
Plaintiffs,	)	
vs.	)	Cause No. IP 81-58-C
RICHARD SCHWEIKER, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; WAYNE A. STANTON, ADMINISTRATOR, INDIANA DEPARTMENT OF PUBLIC WELFARE; and RONALD G. BLANKENBAKER, SECRETARY OF THE INDIANA STATE BOARD OF HEALTH,	)	
Defendants.	)	

PRELIMINARY INJUNCTION

Come now the plaintiffs, by counsel, and having heretofore filed their Verified Complaint for Injunctive Relief, Stay of Administrative Orders and Damages, said complaint being in the following words and figures, to-wit:

(H.I.)

And the plaintiffs having furthermore filed their Motion for Restraining Order and the Court having set the matter for hearing on the 29th day of January, 1981, at 1:30 P.M., and the plaintiffs appearing in person and by counsel, David F. McNamar, Steers, Sullivan, McNamar & Rogers, and the defendant Wayne A. Stanton, Administrator, Indiana Department of Public Welfare, appearing by counsel, Linley E. Pearson, Attorney General of Indiana and Gordon E. White, Deputy Attorney General, and the defendant, Richard Schweiker, Secretary of the United States Department of Health & Human Services, by counsel, Thomas Crawley, staff counsel, United States Department of Health & Human Services, Region V, Chicago, Illinois; and George Palmer, Assistant United States Attorney, Southern District of Indiana, and the Court having heard the evidence and argument of counsel and being duly advised in the premises now finds:

1. That the plaintiffs will suffer irreparable harm and would suffer future threatened injury if injunctive relief, pendente lite, would not be granted in this instance.

2. That affirmative action needs to be ordered to prohibit the detention or withholding of funds which will result if the certifications of each respective nursing home are withdrawn prior to the Court's ruling as to the necessity for administrative hearings.

3. That plaintiffs would be irreparably damaged in that they could not provide adequate patient care, meet expenses, payroll and other items without the protection and orders of the Court herein.

4. That the United States Department of Health & Human Services did not prevent any evidence of any imminent danger to the health or safety of the patients of each facility if they are allowed to remain therein and that, furthermore, these patients would be required to be moved from their facilities if certification is terminated.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED by the Court:

1. The defendant, Richard Schweiker, Secretary of the United States Department of Health & Human Services, and that agency, and Wayne A. Stanton, Administrator, Indiana Department of Public Welfare, and that agency are hereby preliminarily enjoined from decertifying each respective facility as Medicare and/or Medicaid providers pursuant to any decertification proceedings initiated to this date and from withholding, or in any way delaying the processing of claims or the delaying of any funds due plaintiffs when in receipt by or through any of their agents of claims submitted by plaintiffs or from any restrictions as to admission of patients in either facility, until the further order of the Court.

2. That the plaintiffs are to file their Bond, with corporate surety, to be approved by the Court, in the sum of Ten Thousand Dollars ($10,000.00), conditioned for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained, and that the Bond requested by the Court is tendered herewith.

3. That plaintiffs are ordered to file their brief in support of their position on or before February 13, 1981.

4. That defendants are ordered to file their briefs in support of their position on or before March 2, 1981.

5. That this Preliminary Injunction shall be effective from and after 5:30 P.M., January 29, 1981, and that all matters herein are continued until further hearing when ordered by this Court.

/s/ _____

JUDGE S. HUGH DILLIN,
United States District
Court
Southern District of Indiana
Indianapolis Division

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

TURTLE CREEK CONVALESCENT CENTERS, INC., d/b/a NORTHSIDE HEALTHCARE CENTER,	)	
Plaintiff,	)	
vs.	)	No. IP 81-172-C
RICHARD SCHWEIKER, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; WAYNE A. STANTON, ADMINISTRATOR OF THE INDIANA DEPARTMENT OF PUBLIC WELFARE; RONALD G. BLANKENBAKER, SECRETARY OF THE INDIANA STATE BOARD OF HEALTH,	)	
Defendants.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A bench trial commenced on March 9, 1981 and was concluded on March 11, 1981 upon the issues of plaintiff's verified complaint for injunctive relief, stay of administrative orders and damages, the defendants' answers thereto. The matter was advanced on the trial calendar. The Court having heard the evidence and argument of counsel and being duly advised in the premises now finds:

That the plaintiff, Turtle Creek Convalescent Centers, Inc., is an Indiana corporation, doing business as Northside

Healthcare Center, which facility is located at 2140 West 86th Street, Indianapolis, Indiana. That the defendant, Richard Schweiker, is the Secretary of the Department of Health and Human Services, which is the agency responsible for the Medicare Program and is partially responsible for the Medicaid Program which is a cooperative arrangement between the states of the United States and the Federal Government in accordance with Title XIX of the Social Security Act, 42 U.S.C. That the Indiana Department of Public Welfare is the Administrator for the United States Department of Health and Human Services and is responsible for the payment of Medicaid benefits to qualified providers and recipients. That the Indiana State Board of Health is the licensing body for nursing homes in the State of Indiana and is the inspection agency for both the Indiana Department of Public Welfare and the Department of Health and Human Services in insuring compliance with Medicaid regulations.

That on or about the 28th day of January, 1981, defendant Wayne A. Stanton, Administrator of the Indiana Department of Public Welfare sent a letter to Northside Healthcare Center stating that said facility was decertified in the Indiana Medicaid Program. A copy of said letter is attached hereto, made a part hereof and marked Exhibit "A". That counsel for the plaintiff attempted to contact the defendant, Indiana Department of Public Welfare to continue payments pending an administrative hearing which is accorded by the State of Indiana, but was advised by counsel for the Department of Public Welfare that such a hearing was not available and no payments would be made based upon the letter from Health and Human Services included in Exhibit "A". That previously the Indiana Department of Public Welfare had indicated that decertification would occur, however a request for hearing was made and to date no hearing has been accorded the plaintiff. A copy of counsel's correspondence to the Indiana State Board of Health and the Indiana Department of

Public Welfare is attached hereto, made a part hereof and marked Exhibit "B" and "C", respectively. That no emergency exists whatsoever which would require immediate termination of payments in that there are no dangerous or hazardous conditions adversely affecting any of the patients at the facility which would warrant post-termination proceedings. That plaintiff will suffer irreparable harm and injury in that plaintiff will be forced to either remove patients who have no other facility in which to reside or continue to care for said patients without any reimbursement whatsoever which would create an impossible situation and one which is not financially feasible by reason of the cost for nursing care as well as food and other items. That an emergency exists for an immediate restraining order and preliminary injunction by reason of the clearly arbitrary and capricious agency action herein by reason of the immediate cessation of payments for patient care at said facility without any notice or opportunity for a hearing being accorded the plaintiff. That Health and Human Services and the Department of Public Welfare should be enjoined and restrained from any such termination of benefits to plaintiff, Northside Healthcare Center and all other similarly situated patients in said facility until such time as Health and Human Services and the Department of Public Welfare resolve their internal disputes and/or that the plaintiff is accorded a meaningful administrative hearing under the terms and conditions of the Indiana Administrative Adjudication and Court Review Act as accorded it realistically under Indiana law and for compliance by the defendants with the case law as established in *Hathaway v. Mathews*, 546 F.2d 227 (7th Cir. 1976). That the amount in controversy irrespective of interest and costs herein greatly exceeds $10,000.00 considering the loss of revenues from the Federal Financing Program of the Medicaid Act.

That plaintiff was not accorded any hearing whatsoever by defendant, United States Department of Health and

Human Services, prior to notification of final determination of termination of Federal Financial Participation in the Medicaid Program of the Social Security Act, Title XIX. That irreparable harm will occur to plaintiff if the same is not granted in that plaintiff will lose a substantial number of patients for whom medical care and services are needed by them as well as cause financial ruination of plaintiff by termination of Federal Financial Participation to pay for the care of said patients. That the actions of the United States Department of Health and Human Services constitute clearly an arbitrary and capricious action by the agency to the detriment of plaintiff in that no due process of law has been accorded plaintiff and no basis for such a decision exists. That the notice sent by defendant is a final administrative action or determination by an agency of the United States.

That the Secretary had not made a written determination that an immediate or serious threat to the health and safety of patients presently exists and none exists, and that plaintiff is therefore entitled to a hearing by the Secretary, before termination of the agreement by the terms of this new statute. That the plaintiff has furthermore never been specifically advised by Health and Human Services wherein it now fails to comply with regulations of that department and no notice or opportunity for a hearing has existed prior to this arbitrary and capricious action. That by reason of the defendants' actions herein, plaintiff's performance of its requirements and lack of prior notice to the plaintiff herein of the adverse action, plaintiff seeks injunctive relief prohibiting defndant, Health and Human Services, from terminating the Federal Financial Participation of plaintiff in the Medicare and Medicaid Section of the Social Security Act, as well as prohibiting the Indiana Department of Public Welfare from transferring patients or from decertification of plaintiff as an Intermediate Care Facility within the meaning of the Social Security Act which would result in failure to pay

plaintiff funds for care of patients eligible under the Medicaid Program.

Plaintiff has not been damaged as alleged in count four.

The Court has jurisdiction of the parties and subject matter of the action of the respective counts as follows:

Count one, action arises under the laws of the United States of America providing for Social Security and rests upon 42 U.S.C. Chapters 10 and 19, and 28 U.S.C. §1331(a) and §1361.

Count two, action is for review of a final administrative action of an agency of the United States of America. 5 U.S.C. §701, *et seq.* and injunctive relief is authorized by 5 U.S.C. §705.

Count three, action arises under the Omnibus Reconciliation Act of 1980, P.L. 96-499, §916(b)(2) amends §1910 of the Social Security Act, 42 U.S.C. §1320(a)(1).

Count four, is a claim for actual damages and punitive damages.

The plantiff has proved the alleged facts of the essential legal elements of each of counts one, two and three of the complaint.

The defendants have failed to prove the alleged facts of the essential legal elements of each of the affirmative defenses of answer.

That the defendant, Richard Schweiker, Secretary of the United States Department of Health and Human Services, and that agency; and Wayne A. Stanton, Administrator of the Indiana Department of Welfare, and that agency, are hereby enjoined from decertifying Northside Healthcare Facility as a Medicare and/or Medicaid provider pursuant to any decertification proceedings initiated to this date and from withholding, or in any way delaying the processing of claims or the delaying of any funds due plaintiff when in receipt by or through any of their agents of claims

submitted by plaintiff or from any restrictions as to admissions of patients in said facility, and that this injunction is ordered to remain in full force and effect until such time as the United States Department of Health and Human Services shall accord the plaintiff herein a pre-termination evidentiary hearing as is required under the Omnibus Reconciliation Act of 1980, P.L. 96-499.

The plaintiff has failed to prove the alleged facts of each of the essential legal elements of count four.

The law is with the plaintiff and against the defendants upon the issues of counts one, two and three of the complaint and the answers thereto.

The law is with the defendants and against the plaintiff upon the issues of count four of the complaint.

The plaintiff is ORDERED to submit a judgment entry.

Dated this____day of July, 1981.

/s/ Cale J. Holder, Judge,
United States District Court
Southern District of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

TURTLE CREEK CONVALESCENT CENTERS, INC., d/b/a NORTHSIDE HEALTHCARE CENTER,	)	
Plaintiff,	)	
vs.	)	CAUSE NO. IP 81-172-C
RICHARD SCHWEIKER, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERIVCES, WAYNE A. STANTON, ADMINISTRATOR OF THE INDIANA DEPARTMENT OF PUBLIC WELFARE,	)	
RONALD G. BLANKENBAKER, SECRETARY, INDIANA STATE BOARD OF HEALTH,	)	
Defendants.	)	

JUDGMENT ENTRY

This cause having been brought for trial before the Honorable Cale J. Holder, Judge, United States District Court for the Southern District of Indiana without jury on March 9, 1981 and concluding on March 11, 1981, and the plaintiffs herein having appeared by counsel, David F. McNamar, of the firm of Steers, Sullivan, McNamar & Rogers and the defendant, Richard Schweiker, Secretary of the Department of Health & Human Services, by counsel, Alan Dorn, staff counsel for the Department of Health and Human Services and Harold R. Bickham, Assistant United States Attorney; and defendant Wayne A. Stanton, Administrator, Indiana Department of Public Welfare and Ronald G. Blankenbaker, Secretary, Indiana

State Board of Health by counsel, Linley E. Pearson, Attorney General of Indiana and Gary Brock, Deputy Attorney General;

And the Court after due deliberation on the 6th day of July, 1981 made and filed its Findings of Fact and Conclusions of Law and opinion, it is hereby ORDERED, ADJUDGED AND DECREED:

1. That the Court has jurisdiction of the subject matter and of all the persons and parties hereto and that plaintiff's complaint states a claim upon which relief should be granted against the defendants under Court I. in accordance with 42 U.S.C. Chapters 18 & 19 and 28 U.S.C. §1331(a) and §1361(b) under Count II. in accordance with 5 U.S.C. §701 et seq. and injunctive relief being authorized by U.S.C. §705; Count III. an action arising under Acts of 1980, Public Law 96-499, §1916(b)(2) as amends §1910 of the Social Security Act, 42 U.S.C. §1320(a)(1).

2. That the defendants and each of them, their members, agents, employees and any other person authorized to act for in full or in behalf of each respective defendant be and are hereby jointly and severally enjoined:

(a) From decertifying Northside Healthcare Facility as a Medicare and/or Medicaid provider pursuant to any decertification proceedings initiated to the date of this Entry.

(b) From withholding or any way delaying the processing of claims or for the delay of any funds due plaintiff when in receipt by or through any of their agents of claims submitted by plaintiff.

(c) From any restrictions as to admissions of patients in said facility.

3. That this permanent injunction is ordered to remain in full force and effect until such time as the defendant United States Department of Health & Human Services shall accord the plaintiff herein a pre-termination

evidentiary hearing as is required under the Omnibus Reconciliation Act of 1980, Public Law 96-499.

4. That jurisdiction of this cause is retained for the purpose of giving full effect to this order and for the purpose of making such further orders and decrees or taking such further action, if any, as may become necessary or appropriate to carry out and enforce this order.

5. That the plaintiff take nothing as to Count IV. of its complaint.

ALL OF WHICH IS ORDERED this 7 day of July, 1981.

/s/ Cale J. Holder, Judge
United States District Court
Southern District of Indiana
Indianapolis Division

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CARE INNS, INC. d/b/a CLARKSVILLE HEALTHCARE CENTER,	)	
Plaintiff,	)	
vs.	)	No. IP 81-929-C
RICHARD SCHWEIKER, SECRETARY DEPARTMENT OF HEALTH AND HUMAN SERVICES;	)	
ROBERT F. SMITH, ACTING ADMINISTRATOR, INDIANA DEPARTMENT OF PUBLIC WELFARE;	)	
RONALD G. BLANKENBAKER, SECRETARY, INDIANA STATE BOARD OF HEALTH,	)	
Defendants.	)	

FINDINGS OF FACT CONCLUSIONS OF LAW AND JUDGMENT ENTRY

A bench trial commenced on September 2, 1981, and was concluded on September 4, 1981, upon the issues of plaintiff's two count complaint filed August 31, 1981, for injunctive relief and stay of administrative orders, and the defendants' answers thereto. The matter was advanced on the trial calendar and the issues tried on the merits for a final judgment. At the conclusion of the trial, the Court took the matter under advisement pending a post trial briefing

schedule and stayed all action by defendants and vacated order of nonrenewal notice. The Court having heard the evidence and argument of counsel and being duly advised in the premises now finds:

That the plaintiff, Care Inns, Inc., formerly Turtle Creek Convalescent Centers, Inc., is an Indiana Corporation doing business as Clarksville Healthcare Center which is located at 586 Eastern Boulevard, Clarksville, Indiana, and is wholly owned by Healthcare Management, Inc., which owns at least nineteen (19) other long-term healthcare facilities in the State of Indiana. That the defendant, Richard Schweiker, is the Secretary of the Department of Health and Human Services, which is the agency responsible for the Medicare Program and is partially responsible for the Medicaid Program which is a cooperative arrangement between the states of the United States and the Federal Government in accordance with Title XIX of the Social Security Act, 42 U.S.C. §1395 *et seq.* That the Indiana Department of Public Welfare is the Administrator for the United States Department of Health and Human Services and is responsible for the payment of Medicaid benefits to qualified providers and recipients. That the Indiana State Board of Health is the licensing body for nursing homes in the State of Indiana and is the inspection agency for both the Indiana Department of Public Welfare and the Department of Health and Human Services in insuring compliance with Medicaid regulations. Plaintiff is a skilled nursing facility participating in the Medicare and Medicaid Programs. Plaintiff entered into provider agreements with the Secretary of Health and Human Services and with the Indiana Department of Public Health to provide health care services to Medicare and Medicaid beneficiaries for its Clarksville Healthcare Center. The provider agreements were limited to twelve (12) months, and were to expire on August 31, 1981.

Pursuant to the requirements of the Medicare and Medicaid Programs, a facility must be certified annually

as meeting certain conditions of participation in order that is Medicaid and Medicare provider agreement be renewed. Pursuant to Section 1864 of the Social Security Act, 42 U.S.C. §1395aa, the Indiana State Board of Health performs annual surveys on behalf of the Secretary in order to verify compliance with the Medicare conditions of participation. Indiana State Board of Health personnel surveyed plaintiff on May 11 to 14, 1981. The surveyors determined that plaintiff failed to comply with two conditions of participation, a copy of trial exhibit AA is attached hereto and made a part hereof. Based on such survey results, on or about the 21st day of July, 1981, the Administrator of the defendant, Indiana Department of Public Welfare, sent a letter to Clarksville Healthcare Center stating that said facility was to be decertified in the Indiana Medicaid Program, effective September 1, 1981, a copy of trial exhibit 1 is attached hereto and made a part hereof. The plaintiff requested that the defendant, Indiana Department of Public Welfare, conduct an administrative hearing under the law of the State of Indiana and a pretermination hearing in accordance with the Federal Omnibus Reconciliation Act of 1980, P.L. 96-499. To date no hearing has been accorded the plaintiff, a copy of trial exhibits 14, EE, 7, 8 and FF are attached hereto and made a part hereof. Based on the survey results, Indiana State Board of Health forwarded to defendant, Department of Health and Human Services, a recommendation that the plaintiff's skilled nursing facility Medicare agreement not be renewed, a copy of trial exhibit BB is attached hereto and made a part hereof. The plaintiff requested that the Department of Health and Human Services conduct a pretermination hearing in accordance with the Federal Omnibus Reconciliation Act of 1980, P.L. 96-499. To date no hearing has been accorded the plaintiff, a copy of trial exhibits 14 ,EE, 7, 8 and FF are attached hereto and made a part hereof. The evidence of record was reviewed, being trial exhibits AA, BB and CC (trial exhibit CC is also

attached hereto and made a part hereof) by the Department's Bureau of Health Standards and Quality (Bureau). Trial exhibit CC is a report in which the Bureau concluded that the cited deficiencies "immediately jeopardize the safety and welfare of Medicare beneficiaries as well as the quality of care rendered the beneficiaries." By letter dated July 22, 1981, plaintiff was notified by defendant, Department of Health and Human Services, of the nonrenewal of its Medicare skilled nursing facility agreement, as of August 31, 1981. The notice informed the plaintiff that its deficiencies "seriously limit your facility's capability to render adequate care and immediately jeopardizes (sic) the health and safety of your patients." The notice was accompanied by a detailed list of deficiencies. The notice also informed the plaintiff that it had a right to request reconsideration of the nonrenewal decision within sixty (60) days of the date of notice. The notice further stated that the Department of Health and Human Services officials, as part of the reconsideration process, would meet with plaintiff's officials to discuss the findings and that the facility could submit additional evidence at that time, a copy of trial exhibits 2 and 6 are attached hereto and made a part hereof. The plaintiff requested that the Department of Health and Human Services conduct a pretermination hearing in accordance with the Federal Omnibus Reconciliation Act of 1980, P.L. 96-499. To date no hearing has been accorded the plaintiff, a copy of trial exhibits 14, EE, 7, 8 and FF are attached hereto and made a part hereof.

On August 3, 1981 plaintiff initiated a telephone conversation with the Bureau in which the Department of Health and Human Services' decision not to renew plaintiff's provider agreement was discussed. During this conversation, plaintiff indicated that the facility was at that time in compliance with the conditions of participation and expressed the plaintiff's willingness to have the facility resurveyed. After the August 3, 1981 telephone

conversation the plaintiff submitted a plan of action to defendants designed to correct the alleged May 1981 survey deficiencies, a copy of trial exhibits DD, EE, 15, KK and GG are attached hereto and made a part hereof. That on the 5th day of August 1981, the plaintiff sent a letter to Ruth Bouck, R.N. of defendant, Indiana State Board of Health, requesting that a resurvey be conducted of plaintiff's facility prior to September 1, 1981. On August 10 and 11, 1981, pursuant to the facility's request, Indiana State Board of Health personnel conducted a resurvey of the facility. Results of the survey were submitted to the Department of Health and Human Services, a copy of the survey being trial exhibit 6 is attached hereto and made a part hereof. A copy of the August 10 and 11, 1981 survey report was forwarded to the Indiana Department of Public Welfare. That the report of the resurvey of August 10 and 11, 1981 was received by the plaintiff on August 21, 1981 from the Department of Health and Human Services. Plaintiff has never received a report from the Indiana State Board of Health or the Indiana Department of Public Welfare. Plaintiff learned of the report in casual telephone conversation with the Department of Health and Human Services. On August 27, 1981, three officials of plaintiff's facility met with the Department of health and Human Services officials to discuss the nonrenewal decision. Plaintiff was given full opportunity to present its case both orally and in documentary form and did submit additional evidence, including a plaintiff's plan filed august 25, 1981 for correction of the alleged new deficiencies of the August 1981 survey, a copy of trial exhibit 9 is attached and made a part hereof. This evidence has become part of the reconsideration files of the defendants.

It is noted that the State defendant in its notice of July 21, 1981 to plaintiff used the term "decertify" effective September 1, 1981 whereas the Federal defendant in its July 22, 1981 notice to plaintiff uses the term "nonrenewal" effective August 31, 1981. Both terms obviously cannot

have the same meaning. The State decertified as of a date during the life of the provider agreement, that is for the year 1980-1981, whereas the Federal defendant's action declined to renew the provider agreement for the year 1981-1982.

The May survey, it was concluded by both State and Federal defendants, contained deficiencies in plaintiff's operation of the facility (not deficiencies in physical property) that were of such a degree as "immediately jeopardize the safety and welfare" of the recipieitns residents of plaintiff's facility. Such conclusion is suspect in its credibility from the survey itself and from an inference reasonably drawn from the failure of the defendants to close plaintiff's facility forthwith or at least tolerating such danger from May to August 31 or September 1, 1981. The plaintiff's facility was subject to immediate decertification in May of 1981 and removal of the patients within thirty (30) days, if the facility was in such condition as to "immediately jeopardize the safety and welfare" of the recipients. It is obvious that no emergency existed from the time of the May 1981 survey to the time of trial.

The plaintiff's operation is not a "Mom" and "Pop" operation. The plaintiff is knowledgeable in the business and has many provider agreements for its other facilities. Much is expected of this plaintiff's expertise to avoid deficiencies and the likelihood of correction of deficiencies is more dependable. The plaintiff reacted immediately to the July 1981 notices of decertification and nonrenewal of the defendants. The plaintiff's Administrator and Director of Nursing at the Clarksville facility, both of whom were licensed by the State of Indiana, left the plaintiff's organization by their resignation and both now reside in the State of Texas. A competent new licensed Administrator and a competent new licensed Director of Nursing for the facility were engaged by plaintiff to operate the facility. The plaintiff brought there changes about with all deliberate speed in view of the possible exposure to

employee litigation. These new executives set about to correct any deficiencies of which the plaintiff readily admits there were some deficiencies but does not admit and denies that any of the deficiencies "immediately jeopardized the safety and welfare" of the recipient residents. The new executives had a very short time to prepare the facility for the August 1981 resurvey.

The plaintiff will suffer substantial financial losses in excess of $10,000.00 not only by reason of the loss of the recipients' Medicaid and Medicare payments by defendants but will incur a very substantial loss growing out of its contract with the owner of the physical properties based on a nonrenewal of its provider agreements with defendants. The potential loss to plaintiff is irreparable.

The survey process is subjective in that it is susceptible to the personal biases and interpretations of the surveyors. The decision to terminate or nonrenew involves substantial elements of subjectivity in that there is no given number of deficiencies which, if found, would trigger decertification nor is there a formula for determining whether decertification, or any sanction, is required.

The defendants have refused to complete an informal reconsideration of their decision to decertify and/or not to renew before the date such decertification and renewal time was to take effect.

The defendants have refused to certify plaintiff's facility for renewal of the provider agreement for the year 1981-1982. The July 1981 notices of the defendants are final administrative actions, or determinations, of nonrenewal. The July 1981 notices of the defendants constitute the record for this judicial review as the defendants have refused to grant hearings.

The defendants have refused to act on plaintiff's request for reconsideration of their actions of July 1981. The Department of Health and Human Services conducted an

informal hearing in Chicago, Illinois, August 27, 1981 following the early August resurvey. The representative of the Department of Health and Human Services conducting the hearing again concluded that the alleged deficiencies in the resurvey of August 1981 and the May 1981 survey "immediately jeopardized the safety and welfare" of the recipients in the care of plaintiff. The evidence in such August 27, 1981 hearing and the conclusion reached by the Department of Health and Human Services in the August 27, 1981 hearing is a final administrative action, or determination, of nonrenewal and constitute the record for judicial review as defendants have refused to grant hearings.

The Court has jurisdiction of the parties and subject matter of the action of each of the two counts of the complaint. 28 U.S.C. §1331(a). The issues of count one of the complaint arise under the laws of the United States of America providing for Social Security and rests upon 42 U.S.C. Chapters 18 and 19, and the Federal Omnibus Reconciliation Act of 1980, P.L. 96-499, Section 1916 (42 U.S.C. _____). The issues of count two of the complaint present a request for judicial review of final administrative action of an agency of the United States of America under 5 U.S.C. §701 *et seq.*, injunctive relief under 5 U.S.C. §705, and request for judicial review of final administrative action of the Department of Health and Human Services under 42 U.S.C. §504(g). Also a request for a judicial review of final administrative action of the defendants, Indiana Department of Public Welfare and Indiana State Board of Health, under the Indiana Administrative Adjudication Act.

The plaintiff has proved by a preponderance of the evidence all of the essential elements and alleged facts of each of the elements of count one of the complaint.

The plaintiff has proved by a preponderance of the evidence all of the essential elements and alleged facts of count two of the complaint.

The provider agreements between plaintiff and defendants for the one year term of September 1, 1980 through August 31, 1981 were never terminated during the term by plaintiff or either of the defendants. The plaintiff and defendants honored such contract as being in full force and effect during the year 1980-1981 despite any and all of the alleged deficiencies of the facility referred to in the survey of May 1981 and the resurvey of early August 1981.

The defendants' actions directed at renewal for a provider agreement for the term September 1, 1980 through August 31, 1981, therefore, forestall the issue of a pretermination hearing of an issue of terminating the 1980-1981 provider agreement during its year term for the facts, as found, disclose all parties honored the provider agreement for the entire term of that agreement.

This is a case of a predetermination by defendants' actions on July 21 and 22, 1981 and August 27, 1981 of the plaintiff being considered and/or granted provider agreements for the year September 1, 1981 through August 31, 1982.

The Court recognizes that a survey of plaintiff during the term of plaintiff's provider agreements of 1980-1981, that results in certain reported deficiencies may be the basis for the refusal of defendants to enter into provider agreements for the 1981-1982 year. It is obvious that the defendants in their July 21 and 22, 1981 predetermination notices of May 1981 survey included the sanction of nonrenewal of plaintiff's provider agreements for 1981-1982 could have initially noticed plaintiff of the results of the May 1981 survey of plaintiff's facility without including the sanctions of nonrenewal of the provider agreements for the year 1981-1982 that were so included in such notices.

The found facts are that there was no immediate necessity for the fixing of the sanctions of nonrenewal of the provider agreement for the year 1981-1982 as alleged deficiencies did not immediately jeopardize the health and

safety of the Medicaid and Medicare recipients in plaintiff's care.

The defendants made such decisions and sanctions with respect to plaintiff's facility before the plaintiff had a reasonable opportunity, following defendants' determinations and sanctions that plaintiff no longer substantially meets the provisions of §1861j of 42 U.S.C., to correct its deficiencies, and, following this period, was not given reasonable notice and opportunity for a hearing. As found, the defendants made no initial decision of noncompliance and did not accord plaintiff a hearing before adjudging the sanctions against plaintiff. Instead the defendants combined an initial decision of noncompliance by plaintiff and adjudged sanctions without according plaintiff a hearing. This conduct of defendants was in violation of the Federal Omnibus Reconciliation Act effective December 5, 1980, §916(a) (amending §1966 of the Social Security Act) (f)(1), (f)(2) and (f)(3) of P.L. 96-499 (94 Stat. at page 2623).

In the alternative the Court concludes that all of the defendants failed to provide plaintiff with a hearing before concluding on such sanction, or before effecting such sanction in violation of 5 U.S.C. §701 *et seq.*, and/or 42 U.S.C. §402(g), and/or the Indiana Administrative Adjudication Act.

The evidence, as found, does not support the July 21, 1981 and July 22, 1981 rulings and sanctions of the defendants which were final judgments unsupported by any preruling hearing. The evidence, as found, does not support defendants' findings that plaintiff's facility jeopardized the safety and welfare of the recipients in the care of plaintiff. The evidence, as found, does not support defendants' findings of deficiencies in plaintiff's facility that warrant sanctions. The evidence, as found, is that plaintiff had corrected the alleged deficiencies referred to as the basis in the July 21 and 22, 1981 rulings of defendants.

The evidence does not support the August 27, 1981 ruling of the Department of Health and Human Services reaffirming the sanctions of the defendants which was a final judgment unsupported by any pre-trial ruling. The evidence, as found, does not support defendants' findings that plaintiff's facility jeopardized the safety and welfare of the recipients in the care of plaintiff. The evidence, as found, does not support the Department of Health and Human Services' findings of deficiencies in plaintiff's facility that warrants sanctions.

The defendants, Department of Health and Human Services, Indiana Department of Public Welfare and Indiana State Board of Health, acted arbitrarily and capriciously, as found, and concluded upon in the findings of fact and conclusions of law.

The law is with the plaintiff and against the defendants.

The defendants should be enjoined from further enforcing the sanctions of July 21 and 22, 1981 of the nonrenewal of plaintiff's provider agreement for the year September 1, 1981 through August 31, 1982. The defendants are enjoined to recognize the provider agreements as being unaffected by the predetermination sanctions of nonrenewal of July 21 and 22, 1981. All further administrative action upon the May 1981 survey and the August 1981 resurvey by defendants is stayed and defendants are enjoined from taking any further action thereon as the provider agreements are deemed renewed under the law as the plaintiff, as found, has complied with the law during the year 1980-1981 and there is no cause for nonrenewal of their provider agreements for 1981-1982.

The plaintiff is ordered forthwith to submit a judgment in accordance with these findings of fact and conclusions of law.

Dated this 24 day of September, 1981.

/s/ Cale J. Holder, Judge
United States District Court
Southern District of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CARE INNS, INC., d/b/a CLARKSVILLE HEALTHCARE CENTER,	)	
Plaintiff,	)	
vs.	)	CAUSE NO. IP 81-929-C
RICHARD SCHWEIKER, SECRETARY DEPARTMENT OF HEALTH & HUMAN SERVICES; ROBERT F. SMITH, ACTING ADMINISTRATOR, INDIANA DEPARTMENT OF PUBLIC WELFARE; RONALD G. BLNKENBAKER, SECRETARY INDIANA STATE BOARD OF HEALTH,	)	
Defendants.	)	

JUDGMENT ENTRY

This matter having come on for trial before the Court without a jury and the Court having entered Findings of Fact and Conclusions of Law on the 24th day of September, 1981, it is hereby ordered, adjudged and decreed as follows:

1. The defendants and each of them, their members, agents, employees and any other person authorized to act on their behalf of each respective defendant be and hereby is jointly and severally enjoined as follows:

> 1. Defendants are permanently and prohibitorily enjoined from enforcing or attempting to enforce the sanctions of non-renewal and decertification as threatened in the federal defendant's letter of July 22, 1981 and the state defendants' letter of July 21, 1981.

2. The defendants are permanently and manditorily enjoined to recognize the provider agreements of plaintiff as being unaffected by the sanctions of non-renewal and termination as set forth in the federal defendant's letter of July 22, 1981, and the state defendants' letter of July 21, 1981.

3. All further administrative action upon the May, 1981 survey and the August, 1981 re-survey is stayed and defendants are prohibitorily enjoined from taking any further action thereon.

4. Defendants are hereby ordered to renew and continue the plaintiff's provider agreements for the fiscal year commencing August 31, 1981 through September 1, 1982.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Count III of plaintiff's Complaint is dismissed with prejudice as to the federal defendants and is dismissed without prejudice as to the state defendants.

ALL OF WHICH IS ORDERED this 29 day of September, 1981.

/s/ Cale J. Holder, Judge
United States District Court
Southern District of Indiana
Indianapolis Division

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

LAURA HATHAWAY, d/b/a R.N. NURSING HOME, and JUDY CARROTHERS,	)	
Plaintiffs,	)	
vs.	)	CAUSE NO. _____
PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; WAYNE, A. STANTON, ADMINISTRATOR, INDIANA DEPARTMENT OF PUBLIC WELFARE; and RONALD G. BLANKENBAKER, SECRETARY OF THE INDIANA STATE BOARD OF HEALTH	)	
Defendants.	)	

RESTRAINING ORDER AND ORDER FOR HEARING

Come now the plaintiffs, by counsel, and having heretofore filed their Complaint for Injunctive Relief, Stay of Administrative Orders and Damages and Motion for Temporary Retraining Order without Notice and for Preliminary Injunction, said complaint and motion being in the following words and figures, to-wit:

(H.I.)

And the Court being duly advised now finds that said motion should be granted.

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED by the Court that the defendants are temporarily restrained from terminating the Medicaid certification of plaintiff R.N. Nursing Home from removing patients such as Judy Carrothers and others similarly situated who are eligible for Medicaid from said facility or discontinuing payments to plaintiff R.N. Nursing Home for the care of plaintiff Judy Carrothers and others who are Medicaid beneficiaries.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED by the Court that the defendants are prohibited from refusing placement of other Medicaid patients in plaintiff R.N. Nursing Home's facility.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the plaintiff is ordered to post bond in the sum of $25,000.00.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that this Temporary Restraining Order shall remain in effect pending a hearing for preliminary injunction to be held on the 7th day of January, 1981, at 9:30 o'clock A.M.

ALL OF WHICH IS ORDERED this 31st day of December, 1980.

/s/ _____

WILLIAM E. STECKLER
Judge, United States
District Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

LAURA HATHAWAY, d/b/a R.N. NURSING HOME, and JUDY CARROTHERS,	)	
Plaintiffs,	)	
vs.	)	Cause No. IP 80-1267C
PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; WAYNE, A. STANTON, ADMINISTRATOR, INDIANA DEPARTMENT OF PUBLIC WELFARE; and RONALD G. BLANKENBAKER, SECRETARY OF THE INDIANA STATE BOARD OF HEALTH	)	
Defendants.	)	

AGREED ENTRY

Come now the plaintiffs, by counsel, David F. McNamar, Steers, Sullivan, McNamar & Rogers; and comes now defendant, Patricia Roberts Harris, Secretary of the Department of Health and Human Services, by counsel, Bradley L. Williams, Assistant United States Attorney; and comes now defendants Wayne A. Stanton, Administrator, Indiana Department of Public Welfare and Ronald G. Blankenbaker, Secretary, Indiana State Board of Health, by counsel, Gary Shaw, Deputy Attorney General and Gary Brock, Deputy Attorney General, and agree to continue the Temporary Restraining Order issued in the above cause of

action on December 31, 1980, in full force and effect pending a hearing, and further agree to continue the hearing on said Temporary Restraining Order until January 27, 1981, at 9:30 A.M.

Dated: January 14, 1981

STEERS, SULLIVAN, MCNAMAR & ROGERS

By: _____

DAVID F. MCNAMAR
Attorneys for Plaintiffs

UNITED STATES ATTORNEY

By: _____

BRADLEY L. WILLIAMS
Attorneys for Defendants
Patricia Roberts Harris,
Secretary, Department of
Health & Human Services

ATTORNEY GENERAL OF INDIANA

By: _____

GARY SHAW,
Deputy Attorney General

By: _____

GARY BROCK,
Deputy Attorney General

Attorneys for Defendants, Wayne A. Stanton, Administrator, Indiano Department of Public Welfare and Ronald G. Blankenbaker, Secretary, Indiana State Board of Health

APPROVED THIS ____ DAY OF ____, 1981.

_____

JAMES E. NOLAND, *U.S. District Court Judge*

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

LAURA HATHAWAY, d/b/a R.N. NURSING HOME, and JUDY CARROTHERS,	)	
Plaintiffs,	)	
vs.	)	Cause No. IP 80-1267C
PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; WAYNE, A. STANTON, ADMINISTRATOR, INDIANA DEPARTMENT OF PUBLIC WELFARE; and RONALD G. BLANKENBAKER, SECRETARY OF THE INDIANA STATE BOARD OF HEALTH	)	
Defendants.	)	

ENTRY

Comes now the plaintiff, Laura Hathaway, d/b/a R.N. Nursing Home, in person, and by counsel, David F. McNamar and Michael R. Franceschini, of the law firm of Steers, Sullivan, McNamar & Rogers; and comes now Patricia Roberts Harris, Secretary of the Department of Health & Human Services, (now Richard Schweiker), by counsel, Harold R. Bickham, Assistant United States Attorney, and Allen Dorn, staff attorney for the United States Department of Health & Human Services, Region V; and comes now Wayne A. Stanton, Administrator, Indiana Department of Public Welfare, and Ronald G. Blanken-

baker, Secretary of the Indiana State Board of Health, by counsel, Gordon E. White, Deputy Attorney General;

And the Court having heard arguments of counsel and counsel having conceded that there is no factual dispute at the present time, now makes the following Entry:

1. That the Restraining Order heretofore entered on the 31st day of December, 1980, shall remain in full force and effect pending further Order of this Court.

2. That the matter shall be set for hearing for further proceedings on or about the 15th day of March, 1981.

3. That the parties are to prepare and file a Stipulation of Facts prior to the 2nd day of March, 1981, along with any Affidavits of contested facts.

4. That the plaintiffs are to prepare and file their Brief in support of their position on or before the 2nd day of March, 1981.

5. That defendants are to prepare and file any additional authorities and briefs on or before the 2nd day of March, 1981.

6. That this action does not preclude the State from further administrative proceedings relative to any subsequent basis for decertification. The State may file or maintain the same at any time with hearing to be one or after the 15th day of March, 1981.

7. That this Court furthermore orders that any request or requirement of the United States Department of Health & Human Services to require the Indiana Department of Public Welfare to repay any sums already paid to it for the benefit of patients in the plaintiff's facility shall be stayed pending further Order of this Court.

ALL OF WHICH IS ORDERED this 27th day of January, 1981.

/s/ _____

JAMES E. NOLAND, *Judge*
United States District Court
Southern District of Indiana
Indianapolis Division

COPIES TO:

David F. McNamar, 312 Union Federal Building, Indpls., IN 46204
Harold R. Bickham, 246 U.S. Court House, Indpls., IN 46204
Gordon E. White, 219 State House, Indpls., IN 46204

APPROVED AS TO FORM:

APPENDIX C

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

October 8, 1982

Before

HON. WALTER J. CUMMINGS, *Chief Judge*
HON. JOHN L. COFFEY, *Circuit Judge*
HON. GEORGE TEMPLAR, *Senior District Judge**

AMERICANA HEALTHCARE CORP. *et al.*,	)	Appeals from the United States District for the Southern District of Indiana, Indiana Division.
Nos. 81-1522, 81-2482, 81-2755, 81-2872, 81-1507 vs.	)	No. 81-C-58—S. Hugh Dillin, *Judge.*
RICHARD SCHWEIKER, *et al.*	)	No. 81-C-172, 81-C-929—Cale J. Holder, *Judge.*
	)	No. 80-C-1267—James E. Noland, *Judge.*

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *in banc* filed in the above-entitled cause by petitioner-appellees, Americana Healthcare Corporation, Turtle Creek Convalescent Centers, Inc., Care Inns, Inc., and Hathaway, no judge in active service has requested a vote thereon, and all of the judges on the original panel have voted to deny a rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

APPENDIX D

42 U.S.C. §1395cc(f) [Section 1866(f) of the Social Security Act] as added by Section 916(a) of the Omnibus Reconciliation Act of 1980, Public Law 96-499, effective December 5, 1980.

(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the

facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.

42 U.S.C. §1396a(i) [Section 1902(i) of the Social Security Act] as added by Section 916(b)(1)(A) of the Omnibus Reconciliation Act of 1980, Public Law 96-499, effective December 5, 1980.

(i)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the

provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

42 U.S.C. §1396i(c) [Section 1910(c) of the Social Security Act] as added by Section 916(b)(2) of the Omnibus Reconciliation Act of 1980, Public Law 96-499, effective December 5, 1980.

(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Security certifies that the facility has been notified of its deficiencies and has failed to correct them.

42 U.S.C. §§405(g) and (h). (1976)

Judicial review

(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Secretary made for good cause shown before he files his answer, remand the case to the Secretary for further action by the Secretary, and it may at any time order additional evidence to be taken before the Secretary, but only upon a showing that there is new evidence which is material and

that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding: and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or its decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

Finality of Secretary's decision

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings or fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

JAN 20 1983
ALEXANDER L. STEVAS
CLERK

No. 82-839

In the Supreme Court of the United States

OCTOBER TERM, 1982

AMERICANA HEALTHCARE CORPORATION, ET AL., PETITIONERS

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

TURTLE CREEK CONVALESCENT CENTERS, INC., PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

CARE INNS, INC., PETITIONER

v.

ROBERT F. SMITH, ET AL.

CARE INNS, INC., PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

LAURA HATHAWAY, d/b/a R.N. NURSING HOME, PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

REX E. LEE
Solicitor General

J. PAUL MCGRATH
Assistant Attorney General

ANTHONY J. STEINMEYER
ELOLE E. DAVIES
Attorneys

Department of Justice
Washington, D.C. 20530
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QUESTION PRESENTED

Whether the court of appeals correctly held that the district courts lacked subject matter jurisdiction of each of these consolidated cases involving participation by health care providers in the Medicare and Medicaid programs.

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In the Supreme Court of the United States

OCTOBER TERM, 1982

No. 82-839

AMERICANA HEALTHCARE CORPORATION, ET AL., PETITIONERS

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

TURTLE CREEK CONVALESCENT CENTERS, INC., PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

CARE INNS, INC., PETITIONER

v.

ROBERT F. SMITH, ET AL.

CARE INNS, INC., PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

LAURA HATHAWAY, d/b/a R.N. NURSING HOME,
PETITIONER

v.

RICHARD S. SCHWEIKER, SECRETARY OF
HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A-1 to A-31) is reported at 688 F.2d 1072. The opinions of the district courts (Pet. App. A-32 to A-63) are not reported.

JURISDICTION

The judgment of the court of appeals was entered on August 18, 1982. Petitioners' petition for rehearing was denied on October 8, 1982 (Pet. App. A-64). The petition for a writ of certiorari was filed on November 17, 1982. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. 1254(1).

STATEMENT

1. Part A of the Medicare program, as set forth in Title XVIII of the Social Security Act, 42 U.S.C. (& Supp. IV) 1395c *et seq.*, provides coverage for hospital, skilled nursing facility, and home health services for aged and disabled individuals. The pro-

gram is federally funded and is administered by the Secretary of Health and Human Services. A nursing home may participate in the Medicare program, and thus be reimbursed for the cost of serving eligible beneficiaries, by entering into a provider agreement with the Secretary after the Secretary certifies that the facility meets the requirements for a skilled nursing facility. 42 U.S.C. (& Supp. IV) 1395cc; 42 C.F.R. Part 405, Subpart S. In order to be certified and to maintain its certification, the nursing home must meet each of several "conditions of participation" relating to the health and safety of its patients. 42 U.S.C. (& Supp. IV) 1395x(j); 42 C.F.R. Part 405, Subpart K and 489.10. The Secretary utilizes the findings of state health agencies based on on-site surveys in determining whether nursing homes satisfy the conditions of participation. 42 U.S.C. (& Supp. IV) 1395aa; 42 C.F.R. 405.1902. If a certified facility no longer meets the conditions of participation, the Secretary may terminate or decline to renew its provider agreement upon reasonable notice to the facility. 42 U.S.C. (Supp. IV) 1395cc(b)(2)(A); 42 C.F.R. 489.16, 489.53. A dissatisfied facility is entitled to the same administrative and judicial review procedures that are provided under 42 U.S.C. (Supp. IV) 405(b) and 405(g) to social security recipients affected by adverse administrative action. 42 U.S.C. 1395ff(c). *See Mathews* v. *Eldridge*, 424 U.S. 319, 327-332 (1976).

The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. (& Supp. IV) 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980).

This program is administered by the states under Medicaid plans that are consistent with federal statutory and regulatory requirements. 42 U.S.C. (& Supp. IV) 1396, 1396a. Following approval of its plan by the Secretary (42 U.S.C. 1396a(b)), a state is entitled to federal financial assistance for providing medical care to eligible individuals. 42 U.S.C. (& Supp. IV) 1396b(a). A state may enter into a Medicaid provider agreement with a skilled nursing facility that meets federal certification standards. Those standards are identical for both Medicare and Medicaid. 42 U.S.C. 1396a(a)(28); 42 C.F.R. 442.202. A facility is deemed to meet the Medicaid requirements if the Secretary has certified it for participation in the Medicare program. 42 U.S.C. (Supp. IV) 1396i(a)(1); 42 C.F.R. 442.20(a) and (b). If the Secretary terminates or declines to renew a Medicare agreement with a skilled nursing facility participating in both Medicare and Medicaid, the state must terminate or decline to renew that facility's Medicaid agreement. 42 C.F.R. 442.20(b). In such cases, the Medicare review procedures are binding for purposes of the facility's Medicaid participation. 42 C.F.R. 431.153(d). Where the state terminates or refuses to renew the provider agreement of a skilled nursing facility that participates only in Medicaid, the state must provide a hearing either before the effective date of nonrenewal or termination or within 120 days thereafter. 42 C.F.R. 431.153(a) and (b).

Under its Medicaid program, a state may also pay for services provided in intermediate care facilities that are certified by the state as meeting federally specified health and safety standards. 42 U.S.C. 1396d(a)(15); 42 C.F.R. Part 442, Subparts E, F and G. Such services are not covered under the Medicare program. 42 U.S.C. (& Supp. IV) 1395x. An

intermediate care facility whose Medicaid provider agreement has been terminated or non-renewed by a state is entitled to the same state administrative review procedures that are available to Medicaid-only skilled nursing facilities.

2. a. Petitioners Americana Healthcare Corporation, Turtle Creek Convalescent Centers, Inc., and Care Inns, Inc. operate nursing homes that were certified as Medicare and Medicaid skilled nursing facilities. Certification surveys conducted by the Indiana State Board of Health disclosed, however, that the petitioners were not in compliance with numerous federal standards for skilled nursing facilities. Federal officials accordingly notified each petitioner that because it did not meet Medicare conditions of participation its Medicare provider agreement would not be renewed (Pet. App. A-5, A-7 to A-8, A-10, A-12). Each petitioner was furnished with a detailed list of deficiencies supporting such a determination (*ibid.*).[1]

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[1] Petitioner Americana Healthcare Corporation received a four-page statement that included the following deficiencies: "insufficient nurse staff coverage, rehabilitative nursing care services not performed daily, treatments being performed either without physicians' orders or not according to such orders, lack of a clean interior, ineffective asceptic procedures, and food not stored, prepared or served under sanitary conditions" (Pet. App. A-8 n.8). Petitioner Turtle Creek Convalescent Centers, Inc., was informed that its operations were faulty in the following respects: "nursing services not being provided to patients in need of such services, no active rehabilitation program in feeding, bladder training, ambulation and self-care services, patient records lacked pertinent information regarding patient condition, assessment and treatment, and presence of unsanitary conditions relating to dietetic services" (*id.* at A-10 n.11). Petitioner Care Inns' statement of deficiencies listed, among other items, the following: "instances when proper nursing care was not being provided

Federal officials also concluded that petitioners' deficiencies seriously limited their capability to render adequate care and thus placed their patients' health and safety in immediate jeopardy (*id.* at A-27 n.18). Petitioners were informed of their right to request administrative reconsideration and were given an opportunity to submit additional evidence within 60 days of the initial determinations (*id.* at A-5, A-8, A-10, A-12).[2]

Petitioners each requested reconsideration, contending that their facilities were then in compliance with all Medicare requirements (Pet. App. A-5, A-8, A-10, A-13). Pursuant to these requests, the Indiana State Board of Health resurveyed the facilities prior to the effective dates of nonrenewal (*id.* at A-6, A-8, A-10, A-13). These resurveys each demonstrated continu-

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to patients in need of such care, treatment and medication being administered contrary to physicians' orders, supervision of nursing services inadequate, failure to notify physician in case of patient with recent leg amputation having pain, presence of unsanitary conditions relating to dietetic services, required medications frequently unavailable, and no written procedures for preventing spread of infection from linens and dressings" (*id.* at A-12 n.12).

[2] The decision that a provider agreement will not be renewed upon its expiration is an "initial determination" (42 C.F.R. 405.1502) from which a certified facility is entitled to take an administrative appeal. 42 C.F.R. 405.1501-405.1518. If the initial nonrenewal decision is upheld on reconsideration, the facility may obtain a hearing before an administrative law judge. See 42 C.F.R. 405.1510-405.1560. The decision of the administrative law judge may in turn be reviewed by the Appeals Council, 42 C.F.R. 405.1561, the last step in the administrative review process. The decision of the Appeals Council represents the "final decision" of the Secretary subject to judicial review. 42 U.S.C. 1395ff(c); 42 C.F.R. 405.1567.

ing noncompliance with the Medicare conditions of participation (*ibid.*).[3]

Following the results of the resurveys, and rather than continuing administrative review of their claims, petitioners filed separate actions in the United States District Court for the Southern District of Indiana. Each suit was filed before the nonrenewal date of the Medicare provider agreement involved, and sought to enjoin the Secretary from terminating the agreement prior to holding an evidentiary hearing on whether the plaintiff facility was in compliance with applicable federal requirements (Pet. App. A-7, A-9, A-11, A-13). Petitioners also sought to enjoin the mandatory nonrenewal of their Medicaid agreements based on the Medicare nonrenewals (*ibid.*). 42 C.F.R. 440.20(b). Following separate bench trials, the district court granted a preliminary injunction in the case of petitioner Americana Healthcare Corporation (Pet. App. A-32 to A-34) and permanent injunctions in the cases of petitioners Turtle Creek Convalescent Centers, Inc. (*id.* at A-35 to A-43) and Care Inns, Inc. (*id.* at A-44 to A-56), and in each case ordered continuation of the Medicare and Medicaid provider agreements pending the requested hearings.

b. Petitioner Laura Hathaway, d/b/a R.N. Nursing Home, operates an intermediate care facility that was certified under the Indiana Medicaid program. A certification survey conducted by the Indiana State Board of Health in November 1979 disclosed numer-

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[3] Contrary to petitioners' repeated assertions (Pet. 7, 21-22), petitioner Care Inns, Inc. was not found to be in compliance with Medicare conditions of participation on resurvey. Rather, the "resurvey demonstrated that in several respects the facility continued to fail to provide the proper and required nursing care to its patients" (Pet. App. A-13).

ous violations of federal standards for Medicaid intermediate care facilities, and the Indiana Department of Public Welfare subsequently notified the facility that it was to be decertified as a Medicaid intermediate care facility (Pet. App. A-14). The facility requested an evidentiary hearing prior to any decertification action. This hearing, however, was continued by agreement of the parties pending a separate state licensure proceeding (*ibid.*). The Secretary was not a party to either the licensure or Medicaid decertification proceedings. Although a state hearing examiner recommended issuance of a license (*ibid.*), the state continued to seek Medicaid decertification (*id.* at A-31 n.19). Federal officials notified the state that federal financial assistance for payments to the facility would be deferred on the basis of the state's determination that the facility did not meet federal standards (*id.* at A-14 to A-17). See 42 C.F.R. 442.30 and 45 C.F.R. 201.15.

Petitioner subsequently filed an action in the United States District Court for the Southern District of Indiana seeking to enjoin the state from discontinuing payments to the facility and the Secretary from deferring federal assistance prior to an evidentiary hearing on the state's decertification decision (Pet. App. A-17). The district court granted a temporary restraining order that was subsequently extended by agreement of the parties and thereafter by court order (*id.* at A-57 to A-63).

3. The court of appeals consolidated the cases below and, in a single opinion (Pet. App. A-1 to A-31), reversed the district court orders. The court of appeals held that the district court lacked jurisdiction under 28 U.S.C. 1331, 42 U.S.C. (Supp. IV) 405(g) or 28 U.S.C. 1361 to grant the relief sought by peti-

tioners, relying upon this Court's decisions in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and *Mathews* v. *Eldridge*, *supra*, and its own decision in *Northlake Community Hospital* v. *United States*, 654 F.2d 1234 (7th Cir. 1981) (Pet. App. A-18 to A-23).

Jurisdiction under 28 U.S.C. 1331 was found to be precluded by 42 U.S.C. 405(h) (Pet. App. A-18 to A-19). *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 756-762. The court of appeals similarly rejected the claim that 42 U.S.C. (Supp. IV) 405(g) provided jurisdiction in this case. Section 405(g) requires exhaustion of administrative remedies prior to judicial review, and the court concluded that the exhaustion requirement was not satisfied by petitioners' contention that they had raised "a colorable constitutional challenge which is collateral to [their] claim of entitlement and [their] interest in having this issue resolved is so great as to make deference to the agency's judgment inappropriate" (Pet. App. A-21, citing *Mathews* v. *Eldridge*, *supra*, 424 U.S. at 331-332). The court noted that each petitioner "was afforded advance notice of the decision to decertify their respective facility," each was "informed of the deficiencies upon which the decision to decertify the facility was based," and each was "afforded an opportunity for a resurvey to demonstrate any corrections made in the listed deficiencies" and was "permitted to submit documentation explaining or refuting the existence of the deficiencies" (Pet. App. A-22). After listing these procedural protections, the court weighed "the interest in efficient and not unduly expensive administrative procedures as well as the strong government interest in the protection of Medicare and Medicaid recipients" against the "risk that a facility will be erroneously

terminated as a Medicare or Medicaid provider," and concluded that petitioners "have failed to establish a colorable claim of constitutional entitlement to a pre-termination hearing" (*ibid.*). In these circumstances, the court of appeals determined that the exhaustion requirement of Section 405(g) was not waived and that the district courts lacked jurisdiction under that section.

The court of appeals also rejected petitioners' assertion that the district courts had mandamus jurisdiction pursuant to 28 U.S.C. 1361 and Section 916(a) of the Omnibus Reconcilation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2623, 42 U.S.C. (Supp. IV) 1395cc(f) (Pet. App. A-65 to A-66), which amended the Social Security Act to provide certain alternative procedures to the decertification of skilled nursing care facilities found to be in noncompliance with standards for Medicare participation (Pet. App. A-23 to A-31). After a careful analysis of 42 U.S.C. (Supp. IV) 1395cc(f) and its legislative history, the court concluded that it afforded no "clear right to a pre-termination hearing" and that mandamus jurisdiction was therefore inappropriate (Pet. App. A-30 to A-31). Finally, the court rejected Care Inns' contention that the district court had properly exercised pendent jurisdiction over its claim of entitlement to a pre-termination hearing under Indiana law, since there did not then exist a federal claim of " 'substance sufficient to confer subject matter jurisdiction on the court' " (*id.* at A-31, quoting *United Mine Workers* v. *Gibbs*, 383 U.S. 715, 725 (1966)).

ARGUMENT

The decision of the court of appeals is consistent with this Court's opinions in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and *Mathews* v. *Eldridge*, 424 U.S. 319 (1976). It is also in accord with the unanimous conclusion of the federal courts of appeals that Medicare providers have no due process right to a pre-termination hearing.[4] Accordingly, further review by this Court is unwarranted.

1. Petitioners initially contend (Pet. 11-17) that the district court has mandamus jurisdiction pursuant to 28 U.S.C. 1361 to compel the Secretary to grant pre-termination hearings. The court of appeals correctly rejected this assertion.

As noted by the court of appeals (Pet. App. A-25), mandamus may properly issue only when three elements are present: (1) the plaintiff possesses a clear right to the relief sought, (2) there is a plainly defined and peremptory duty on the part of the defendant, and (3) no other adequate remedy is available. *Lovallo* v. *Froehlke*, 468 F.2d 340, 343 (2d Cir. 1972), cert. denied, 411 U.S. 918 (1973); *Cervoni* v. *Secretary of Health, Education and Welfare*, 581 F.2d 1010, 1019 (1st Cir. 1978). Furthermore, "[w]hen the performance of official duty calls for a construction of governing law, the [federal] officer's interpretation will not be disturbed by a writ of mandamus unless it is clearly wrong and his official action is arbitrary and capricious." *Association of American Medical Colleges* v. *Califano*, 569 F.2d 101, 110 n.80 (D.C. Cir. 1977). Petitioners do not have a "clear

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[4] The Court declined to review claims identical to those raised by petitioners in *Geriatrics, Inc.* v. *Harris*, 640 F.2d 262 (10th Cir.), cert. denied, 454 U.S. 832 (1981).

right" to a pre-termination hearing, nor does the Secretary have a plainly defined and peremptory duty to accord them such a hearing. Petitioners, furthermore, have access to fully adequate post-termination administrative and judicial hearings. Accordingly, petitioners have no basis upon which to predicate their claim to mandamus jurisdiction in this case.

Petitioners' mandamus arguments rest squarely upon what they assert is the clear command of Section 916(a) of the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2623, 42 U.S.C. (Supp. IV) 1395cc(f). Petitioners submit that this section requires a pre-termination hearing whenever the Secretary terminates a facility's Medicare certification. The section, however, does not mandate such a result.

42 U.S.C. (Supp. IV) 1395cc(f) provides, in pertinent part:

> (1) Where the Secretary determines that a skilled nursing facility * * * no longer substantially meets the provisions of section 1395x(j) of this title, and further determines that the facility's deficiencies—
>
> > (A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or
> >
> > (B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide
>
> that no payment shall be made under this subchapter * * * with respect to any individual admitted to such facility after a date specified by him.

> (2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1395x(j) of this title, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

When enacted, Section 1395cc(f) was entitled "Alternative to Decertification of Long-Term Care Facilities Out of Compliance with Conditions of Participation * * *" (Section 916, Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2623). The alternative sanction created by the section—denial of payment for patients admitted after a specified date—may be utilized by the Secretary "in lieu of terminating the agreement or certification of the facility" (42 U.S.C. (Supp. IV) 1395cc(f)(1)(B)). Section 1395cc(f), however, clearly does not supplant the existing authority of the Secretary to terminate Medicare certification.[5] Thus, the pre-existing provisions of the Social Security Act, which set forth the grounds and procedures for termination of provider agreements as well as the administrative review of such actions, are unchanged by the 1980 legislation. 42 U.S.C. (Supp. IV) 1395cc(b)(2), 42 U.S.C.

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[5] The alternative sanction provided by Section 1395cc(f), moreover, may only be applied in circumstances that "do not immediately jeopardize the health and safety" of Medicare patients (42 U.S.C. (Supp. IV) 1395cc(f)(1)(B)). If a facility's noncompliance does immediately jeopardize patients' health or safety, the Secretary is required to terminate the provider agreement (42 U.S.C. (Supp. IV) 1395cc(f)(1)(A).

1395ff(c).[6] And, contrary to petitioners' assertions (Pet. 7, 19), these provisions do not provide for post-termination hearings.[7]

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[6] 42 U.S.C. (Supp. IV) 1395cc provides in pertinent part:

> (b) An agreement with the Secretary under this section may be terminated * * *
>
> (2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in the regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this subchapter and regulations thereunder or (B) that such provider of services no longer substantially meets applicable provisions of section 1395x * * *.

42 U.S.C. 1395ff(c) provides in pertinent part:

> Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services * * * shall be entitled to a hearing thereon by the Secretary * * * to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

[7] From the inception of the Medicare program, 42 U.S.C. (Supp. IV) 1395cc(b)(2) has stated that a provider agreement may be terminated "by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations * * *." The original legislative history states that a hearing is required only before a "final" decision of the Secretary. S. Rep. No. 404 (Pt. I), 89th Cong., 1st Sess. 51 (1965). Moreover, 42 U.S.C. 1395ff(c), as enacted in 1965, accords dissatisfied facilities the same post-termination hearings as are provided under 42 U.S.C. (Supp. IV) 405(g) to social security recipients whose benefits have been terminated. *Mathews* v. *Eldridge*, 424 U.S. 319

Petitioners' claims of entitlement to pre-termination hearings are based solely upon the wording of subsection (2) of Section 1395cc(f). That subsection provides that the Secretary shall not make "such a decision with respect to a facility" until the facility has been given "reasonable notice and opportunity for a hearing" (42 U.S.C. (Supp. IV) 1395cc(f)(2)). Petitioners assert that this hearing requirement applies to the decision to terminate a provider agreement as well as to the decision to apply the alternative sanction created by Section 1395cc(f). The court of appeals properly rejected this argument.

The court of appeals correctly noted that subsection (1)(A) of Section 1395cc(f) "requires the termination sanction in cases where the conditions of 'immediate jeopardy' to health and safety are found to exist" (Pet. App. A-28). The court therefore concluded that to construe subsection (2) of Section 1395cc(f) as applying to the termination decision "leads one to the anomalous situation of permitting a skilled nursing facility to continue treating patients under conditions which the Secretary has concluded place the patients' very health and safety in 'immediate jeopardy' while the facilities are afforded a time consuming pre-termination hearing" (Pet. App. A-27).[8]

(1976) (post-termination hearing under 42 U.S.C. (Supp. IV) 405(g) complies with the requirements of due process). Neither 42 U.S.C. (Supp. IV) 1395cc(b)(2) nor 42 U.S.C. 1395ff(c) has been amended in relevant part since 1965.

[8] Petitioners concede that the court of appeals' holding was designed "to avoid a result wherein the Secretary would be prevented from removing patients from an unsafe environment by providers who would exploit appeal procedures to avoid termination from Medicare or Medicaid and, in so doing, would unnecessarily prolong the presence of patients in

The court of appeals' conclusion that the subsection (2) hearing requirement applies to the decision to utilize the alternative sanction but not the termination sanction is supported by pertinent legislative history. The House Report on the Omnibus Reconciliation Act of 1980 explains that the new legislation provides the Secretary with "an intermediate sanction, short of the more drastic step of program termination" (H.R. Rep. No. 96-1167, 96th Cong., 2d Sess. 56 (1980)). The report states that this intermediate sanction will be applied "only after the Secretary has provided the facility with an opportunity to present its case at an

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unsafe surroundings" (Pet. 15-16). Without attacking the basic soundness of this reasoning, petitioners merely argue that it "misapprehends the position of the Secretary," who petitioners contend is "merely * * * a fiscal agent," while "[m]onitoring the compliance of facilities with Medicare or Medicaid conditions of participation is the function of state inspectors" (*id.* at 16). Such assertions are unpersuasive and groundless. The fact that Congress chose to utilize the resources of available state licensing agencies to make findings regarding the compliance of facilities with the "conditions of participation" (42 U.S.C. (& Supp. IV) 1395aa) does not derogate from the Secretary's primary responsibility of ensuring compliance with Medicare health and safety requirements. These requirements were developed by the Secretary (42 C.F.R. Part 405, Subpart K) and provide that a state license to operate is only one of many criteria for Medicare certification. 42 U.S.C. 1395x(j)(9); 42 C.F.R. 405.1120(a). The findings of the state agencies represent recommendations to the Secretary and are reviewed by trained federal officials, including federal health care professionals, who make the final determination concerning a facility's eligibility to participate in the Medicare program. 42 U.S.C. (Supp. IV) 1395aa(a), 42 C.F.R. 405.1902(b). Indeed, 42 U.S.C. (Supp. IV) 1395cc (f) itself provides that the *Secretary* shall determine whether a facility satisfies Medicare standards or whether the facility's deficiencies immediately jeopardize patient health and care.

informal hearing consistent with current practices" (*ibid.*). The prompt termination sanction, however, was clearly intended to remain applicable in cases of "immediate jeopardy." "[T]he committee believes that [the Section 1395cc(f)] sanction should not be used as an alternative in situations where a noncomplying facility's deficiencies place the health and safety of its patients in immediate jeopardy; instead, the response for the Secretary in such cases must be to deny all reimbursement of additional patients and to make appropriate arrangements for the orderly, planned transfer of existing patients" (H.R. Rep. No. 96-1167, *supra*, at 57). The House Report's explicit discussion of a pre-sanction hearing when the alternative sanction is imposed, its failure to explicate such a requirement for situations requiring the termination sanction, and its emphasis on prompt effectuation of the termination sanction all support the court of appeals' conclusion that subsection (2) does not apply to the termination sanction.[9] "It is ludi-

[9] Petitioners claim (Pet. 15) that principles of statutory construction require that the phrase "such a decision" in subsection (2) be read as applicable to each of the determinations in Section 1395cc(f), including the initial determination that the facility no longer meets the conditions of participation. But qualifying words, phrases, and clauses often refer to the immediately preceding word, phrase, or clause, and should not be construed as extending beyond their first antecedent unless the context indicates otherwise. *United States* v. *Pritchett*, 470 F.2d 455, 459-461 (D.C. Cir. 1972). Here, the context of Section 1395cc(f), as well as its legislative history, indicates that the provisions of subsection (2) do not apply where the Secretary terminates Medicare certification instead of imposing the alternative sanction.

Petitioners also cite (Pet. 16) a passage from the House Conference Report in which the conferees state that "it is not the intention of this provision to alter access to a full eviden-

crous to believe that the legislature intended to permit the appeal procedures to act as a roadblock to the prompt removal of patients for their own protection and safety from substandard facilities" (Pet. App. A-27).

Because Section 1395cc(f) does not provide for a pre-termination hearing in cases where a health facility's noncompliance with federal standards requires termination of the Medicare or Medicaid providers' agreement, petitioners in this case have no "clear right" to the relief sought.[10] The court of appeals correctly concluded that mandamus jurisdiction was unavailable on the facts of this case.[11]

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tiary hearing before decertification of a facility occurs, as provided under current law." H.R. Conf. Rep. No. 96-1497, 96th Cong., 2d Sess. 141 (1980). However, since "current law" in 1980 with respect to Medicare and joint Medicare-Medicaid skilled nursing facilities did not (and does not) provide for hearings prior to decertification (see note 7, *supra*), in referring to a full evidentiary pre-termination hearing "as provided under current law," the conferees must have been referring to 42 C.F.R. 431.153, which grants states the *option* to provide pre-termination hearings to Medicaid-only facilities.

[10] Inasmuch as it found that the petitioners had no "clear right" to a pre-termination hearing, the court of appeals found it unnecessary to determine whether mandamus jurisdiction is precluded in any event by 42 U.S.C. 405(h) (Pet. App. A-31). This Court has not directly addressed the issue. *Califano* v. *Yamasaki*, 442 U.S. 682, 698 (1979). However, since the court of appeals did not reach the issue there is no conflict to be resolved between this case and *Ellis* v. *Blum*, 643 F.2d 68, 78 (2d Cir. 1981), on which petitioners rely (Pet. 16-17) in urging that mandamus relief is available to review the Secretary's actions where procedural challenges are involved.

[11] Petitioners contend that "at a minimum" they are entitled to a pre-termination hearing where the health and safety of

2. Petitioners next contend (Pet. 17-22) that subject matter jurisdiction is available under 42 U.S.C. (Supp. IV) 405(g)[12] because they have raised constitutional claims that may be heard prior to full exhaustion of their administrative remedies. However, the court of appeals, relying on this Court's decision in *Mathews* v. *Eldridge*, *supra*, 424 U.S. at 332, and its previous holding in *Northlake Community Hospital* v. *United States*, 654 F.2d 1234 (7th Cir. 1981), properly

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their patients are not immediately jeopardized (Pet. 13), and they assert that the district courts properly found no immediate threat to the health or safety of their patients (*id.* at 13-16). The notice of deficiency sent to petitioner Care Inns, Inc., however, specifically stated that the facility's shortcomings "immediately jeopardized the health and safety of the patients" (Pet. App. A-12), and the notices sent to Americana Healthcare Corporation and Turtle Creek Convalescent Centers, Inc., stated that the homes' substandard conditions "seriously limit your * * * capability to render adequate care and insure the health and safety of your * * * patients" (*id.* at A-27 n.18). The court of appeals correctly determined that, notwithstanding the apparent conclusions of the district courts, the question of whether a situation of emergency or "immediate jeopardy" exists is "more appropriately deferred to the expertise of the licensing agency and it is not a proper consideration for a court under mandamus jurisdiction where a clear right to a pre-termination hearing is required" (*id.* at A-30). Such deference to the expertise of professionals who are trained and experienced in evaluating compliance with Medicare and Medicaid regulations is clearly justified. "[T]here certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions." *Youngberg* v. *Romeo*, No. 80-1429 (June 18, 1982), slip op. 15.

[12] 42 U.S.C. 1395ff(c) provides that a facility whose agreement is terminated has the right to a hearing and to judicial review of the final decision made after the hearing as provided in 42 U.S.C. (Supp. IV) 405(g).

rejected this argument. The court held (Pet. App. A-22) that petitioners had not presented a "colorable" constitutional claim to a pre-termination judicial hearing in view of the many procedural protections that they had been afforded at the administrative level. These protections included: advance notice of the decision to decertify the facility as a Medicare and/or Medicaid provider and of the deficiencies upon which the decertification was based, an opportunity for a resurvey to demonstrate any corrections made in the listed deficiencies or to refute the existence of the deficiencies, and, in the case of petitioner Care Inns, an opportunity to meet with Department of Health and Human Services personnel to submit evidence of compliance with applicable conditions of participation prior to termination (*ibid.*) In so holding, the court of appeals joined all other courts of appeals that have considered the issue. *Geriatrics, Inc.* v. *Harris*, 640 F.2d 262 (10th Cir.), cert. denied, 454 U.S. 832 (1981); *Green* v. *Cashman*, 605 F.2d 945 (6th Cir. 1979); *Caton Ridge Nursing Home, Inc.* v. *Califano*, 596 F.2d 608 (4th Cir. 1979); *Town Court Nursing Center, Inc.* v. *Beal*, 586 F.2d 266 (3d Cir. 1978); *Case* v. *Weinberger*, 523 F.2d 602 (2d Cir. 1975). Thus, no reason exists for this Court to review the court of appeals' holding here.[13]

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[13] While this Court has not directly decided whether Medicare providers have a due process right to pre-termination hearings, the Court held in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), that a decertified facility's patients have no right to contest their facility's decertification. The *O'Bannon* Court observed, moreover, that the patients "argue that [their alleged third party beneficiary status] somehow entitles them to more than [the provider] itself is entitled to—namely, a pretermination hearing" (*id.* at 785 n.17). The Seventh Circuit has characterized this

3. Petitioners' last contention is that 42 U.S.C. 405(h) does not bar jurisdiction pursuant to 28 U.S.C. 1331 over their claims against the Indiana Department of Public Welfare (Pet. 22-24). They argue that the court of appeals' decision that the district court did not have pendent jurisdiction over petitioner Care Inns' claim against the Indiana Medicaid authorities conflicts with the Third Circuit's decision in *Town Court Nursing Center, Inc.* v. *Beal, supra*, which found Section 1331 jurisdiction over a nursing home's independent claims against a state defendant.

Petitioners' reliance on *Town Court* is misplaced on several grounds. First, the court of appeals cor-

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observation as "persuasive, if not dispositive, dicta" that providers are not constitutionally entitled to pre-termination hearings. *Northlake Community Hospital* v. *United States, supra*, 654 F.2d at 1242.

Contrary to petitioners' contentions (Pet. 18-22) there are no factors peculiar to their status as providers of skilled nursing care that would warrant a departure from the teachings of *Eldridge* and the numerous subsequent court of appeals decisions dealing with access to pre-termination hearings. As the Seventh Circuit noted in *Northlake Community Hospital* v. *United States, supra*, 654 F.2d at 1242, a provider's interest in the termination of a Medicare agreement is "less weighty" than the interest of a disability claimant in the termination of his benefits since the provider is not the intended beneficiary of the Medicare program. Moreover, the decision to terminate a provider agreement is an easily documented, sharply focused decision in which issues of credibility and veracity play little role (*ibid.*). Finally, the government has a twofold interest in expeditious provider termination—first, to assure the safety and care of elderly patients, and second, to minimize administrative expenses (*ibid.*). These factors are plainly sufficient to overcome a Medicare provider's interest in a pre-termination hearing.

rectly decided that 42 U.S.C. 405(h) bars federal question jurisdiction over petitioners' claims against both federal and state defendants (Pet. App. A-31). *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 756-762. Since the Secretary's regulations require a state to terminate a skilled nursing facility's Medicaid agreement once the Department of Health and Human Services decides to terminate or not renew its Medicare agreement (42 C.F.R. 442.20(b)), to allow a facility to challenge the state decision under 28 U.S.C. 1331 would circumvent the Social Security Act's scheme of permitting judicial review only under 42 U.S.C. (& Supp. IV) 405(g) and (h) after available administrative remedies have been exhausted. Second, in *Town Court*, the facility alleged that the state defendant had an independent obligation to continue Medicaid funding irrespective of the availability of federal reimbursement. 586 F.2d at 279. In contrast, petitioners here assert no such independent obligation on the part of the Indiana defendants. Indeed, they claim that Indiana law prohibits the payment of state Medicaid funds to reimburse a provider when federal funds are not forthcoming (Pet. 5-6). Finally, in holding that pendent jurisdiction to decide the claim of Care Inns was unavailable (Pet. App. A-31), the court of appeals correctly applied the principle enunciated in *United Mine Workers* v. *Gibbs*, 383 U.S. 715, 725 (1966), that pendent jurisdiction is a discretionary doctrine that requires a federal claim of "substance sufficient to confer subject matter jurisdiction on the court."

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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